EDITORIAL

SAANZ began as an attempt to replace the ANZATSA Newsletter, which was edited by Narci Sutton and then myself. The ANZATSA newsletter functioned as the primary communication organ established by the Association, to promote the sharing of research and the interests of the field. Past President, Ms. Kathryn Barribal encouraged the development of the journal and succeeding Presidents and executive committees have provided ongoing strong support for the journal. After quite a lot of discussion, it was decided to move to a full hard copy journal rather than an Internet presence, and to provide a high quality production to maintain the goals of the Association, but also to broaden the interest base for the Association and the work of its members. The journal produced its first issue in 2008. Five issues (three volumes later) I have stepped down from the Editor's position. The journal has benefitted from strong support in its early issues from a panel of leading National and International researchers in the field who provided a number of important submissions, helping to establish the scientific credibility of the journal. The journal remains an organ of the Association, and remains sensitive to the amount of support Association members provide it.

Working with victims of, or perpetrators of, sexually abusive behaviour is a specialty field. It elicits both strong passions and strong aversions. Effective assessment and treatment reduces the potential supply of offenders, and is an essential component of 360 degree approaches to social problems. To be effective, such approaches have to be both clinically and empirically informed. It is therefore absolutely vital that work in both areas is fuelled by knowledge, as well as therapeutic or assessment skill. Technical knowledge has the irritating habit of evolving rapidly rather than slowly. It remains a debated topic in mental health education as to what extent the scientist practitioner model applies to the field of sexual abuse, both victims and perpetrators. However, good practitioners are those who remain in tune with the knowledge base of their profession and areas of interest: the journal was designed to help achieve this. Knowledge is best consumed and remembered by active participation in knowledge generation – that is, a good practitioner will be one who is also involved in research. The journal was to be the natural home for such experts. Unfortunately, the journal has not benefitted adequately by members of ANZATSA taking up the challenge of contributing to their field. There is some demonstration of "action research" and case study approaches that show the worth of the journal in addition to larger empirical studies, program evaluations and literature reviews. I have provided a thematic review of the contributions to the journal to date later in this issue.

The closer ties being forged with VOTA may assist in broadening the appeal of the journal, its contribution base and its readership. The Association should not be concerned if that requires a change in name to reflect the broader role it takes. As forensic practitioners, our clients often stubbornly refuse to be easily pigeonholed and we have to develop a broad skill set to provide the best possible treatment and understanding to our clients. In my opinion, the best social policy approach to a problem is to work simultaneously on both the demand side and supply side.

In closing, this journal came into existence because of the strong support for its creation from Kathryn Barribal initially, then from Gerard Webster and the ANZATSA Executive, and critically by the incredibly helpful and cheaply costed labour of Dr. Tracey Wright, the editorial assistant who basically makes the journal what it is, and also by a small band of reviewers who have been responsive to the call for reviewing. Finally, without contributors, it has no existence at all and our thanks to them is extended. Not every submission was accepted. Some submissions required more development but all who contributed, published or not, are appreciated. The journal has moved into the safe hands of Associate Professor Doug Boer and Dr. Katie Seidler. So please, get your problem finding eyes on, your ethics applications written, your stats packages whirring, and your quills sharpened: and most importantly contribute!

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Invited Paper: A Thematic Analysis of Contributions to SAANZ 2008-2011

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Abstract

An analysis of the contributions to SAANZ over its first five issues finds several themes that have received considerable attention, such as theory development and offender profiling/assessment. A number of areas remain poorly represented, such as young offenders, internet offenders, or cultural aspects of offending, and some areas not at all. For instance, no papers on female offending and none on working with survivors of sexual abuse and their families have been received. A need exists to broaden the topics covered by SAANZ so as to meet its original guidelines and to promote research activity by professionals working in the field of sexual abuse.

Introduction

The Australia New Zealand Association for the Treatment of Sexual Abuse is dedicated to community protection and safety, through the promotion of professional standards, practices and education in sexual abuse prevention, assessment, intervention and research (http://www.anzatsa.org). A quick glance through the index of the first five issues of SAANZ provides a good review of the depth of issues professionals in the field of sexual abuse have to grapple with. The following analysis is both descriptive: identifying what has been done, and proscriptive: what gaps are found and what could usefully be contributed. I hope it provides opportunities for future research and contributions to the journal.

Good science in the mental health field should be able to describe the phenomenon (in this case sexually abusive behaviour) under study, to explicate the central features of the behaviour, predict the circumstances under which the behaviour may occur (or factors that might cause the behaviour to desist) and, lastly, effectively intervene to alter the likelihood of the behaviour occurring again. In the first editorial in Volume 1(1) I wrote:

> *Sexual Abuse in Australia and New Zealand is a new journal with a number of main areas of focus. First, we are conscious of the need to take into account contextual and cultural themes in developing our evidence base and look forward to collaborations with indigenous as well as international colleagues in order to progress our goals. Second, the journal aims to provide a means for people working in the Oceania and Australasia region to know what is happening and what is best practice within their region. We hope in doing this to foster collaborations and shared solutions to what are entrenched problems. Finally, we hope to promote what is best about our practice and share it with the international stage.* (Editorial, 2008, 1)

The following analysis is thus a report card on the extent to which these lofty aims were met. The following matrix was developed to help describe the papers published. Inevitably many articles cover more than one specific area, for example our first paper, Yates & Ward (2008) presents a discussion of theory development but the paper ranges across public policy, offender management, offender treatment and offender assessment issues. However, the matrix serves to capture the main focus of the paper.

Results and Discussion

In considering the submissions to SAANZ it is notable to see where the submissions are concentrated. Theory development and assessment remain important focii, showing the strong relationship between theoretical and scientific developments in our field, and the production of assessment and intervention strategies deriving from those developments. There are two broad areas within theory development specifically with respect to working with sexual offenders - those of proposing and/or fine-tuning theories about how to effect therapeutic change in offenders, and cognitive distortions. The debate on whether cognitive distortions are causative in offending or represent post-offence justifications is an important one, as treatment is

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Table 1. Matrix

Domain	Authors and submission description	Future directions.
Offender Management	(1) Watson and Vess (2008). This paper explores what happened to released sex offenders since the enactment of Extended Supervision legislation in New Zealand. This paper should be read in conjunction with Vess (2009) Vol 1(2). Paper type: Empirical research with use of non parametric analysis.	The paper reflects a core concern of clinicians and policy makers in considering the response to release of sex offenders, and how political and legislative climates can impact on recidivism. Seidler (2010) also discusses similar themes from the perspective of the offender. The outcomes of the paper are challenging, showing that risk level interacts with the legislative regime. Of interest was the finding that the most common offence by a released sex offender was an administrative or breach of conditions offence, the higher scrutiny provided by the legislation led to more administrative breaches. Hence, investigation of longer term responses to the legislation of high and low risk sex offenders released into the community and how that impacts on recidivism rates appears vital.
	(2) Willis (2010). This paper extends research by the author into coding and identifying factors associated with recidivism post release. The argument is that poor release planning is a risk factor for recidivism, raising the prospect of an offender living in an unstable and poorly supported environment. The study makes use of the Good Lives Model (see Yates & Ward, 2008) as the foundation for considering what is good release planning. The study found a direct relationship between paucity of release planning and time to first post release offence. The public policy implications of such findings seem clear, but frequently go unheeded. Paper type: Short report - Reanalysis of previously published data.	The study provides a coding system for considering what is a good pre release plan. The coding system (obtainable from the author) provides a convenient heuristic for replication and evaluation of post release practices.
	Hansen-Reid (2011). The paper is a case study of a person, possibly assessable as having Gender Identity Disorder, and her approach to treatment in a correctional environment (an all male gaol). The cultural, gender and treatment issues are exposed in what is, eventually, a rather sad tale. Paper Type: Case study.	Careful and thoughtful observation of our clients can provide rich information that can lead to hypothesis generation. It is generally accepted in medicine that provision of well constructed observations of the unusual case furthers clinicians ability to provide appropriate interventions to clients they may not have otherwise been prepared for in their training and experience to date.
Offender Treatment	(1) Toman & Hawkins (2008). The paper presents a therapeutic model of negotiation to deal with resistance in treating sex offenders. Paper type: exposition of treatment techniques	The paper advocates a potentially useful treatment approach to dealing with resistance. It should be read in conjunction with the papers in Vol 2 (1) Marshall, Marshall & Ware (2009) and Vol 3 of SAANZ, Winship, Straker & Robinson (2011) and Prately & Goodman-Delahunty (2011). Opportunities for further research include the operationalisation of the technique and effectiveness research into treating resistant sex offenders.
	(2) Collins, Peters, & Lennings (2009). This paper outlines the development of community based, group treatment programs for sex offenders. It	This paper outlines a methodology for assessing community based group treatment programs. It reflects some of the concerns raised by Ware,

	provides an analysis of one such program, based on Christian principles. Paper type: Empirical research using descriptive and some parametric analysis.	Mann & Wakeling (2009) as to how to establish group based programs in the community, such as whether to have open or closed groups, and reflects concerns about how to assess outcomes with community participants who are hard to follow up and who seek privacy and anonymity. The paper could be read in conjunction with Pratley and Goodman-Delahunty (2011) also evaluating a community based group treatment program.
	(3) Ware, Mann, & Wakeling (2009). This paper sets out to establish what is known and what needs to be known about group based treatment for sex offenders. It is an authoritative review of the area, outlining many of the crucial debates in treatment settings such as adherence to manualised treatments, type of groups, nature of treatment used (relapse prevention etc.), and contrasts what is known about group treatment with the general psychotherapy literature and individual treatment. Paper type: Scholarly review.	The paper outlines a fertile field for future researchers working in group base programs, whether they be in closed or community settings, and mandated or volunteer programs. The paper also serves as a good checklist against which current programs might be measured, to see to what extent the programs are conscious of, and make use of, contemporary research findings into group based programs.
	Pratley & Goodman-Delahunty (2011). The paper is an evaluation of a community based treatment program for incest offenders. The paper is also a well constructed review of factors critical to passage through the treatment program. The paper should be read in conjunction with Marshall, Marshall & Ware (2010) for the debate around the weight therapists should give to denial and minimisation. The paper also complements the Collins et al., 2009 evaluation of a community sex offender program,. Paper Type: Empirical research with parametric analysis.	Treatment programs allow for considerable scope in research, including theory testing, psychometric validation of assessment tools, exploring treatment variables, and outcome evaluation. The current study is a good example of the use of evaluation data to test theoretical developments along with contributing to, the as yet small database, on community based group treatment evaluations.
Offender Assessment	(1) Smallbone & Wortley (2008). The authors present a paper exploring the criterion and predictive validity of the Static 99 on child molesters. Paper type: Empirical research with parametric statistical analysis	There are only a few research attempts to validate the Static 99 in Australia. This research assists in providing the necessary authority to use a common risk assessment tool in Australia. Ongoing research into the use of risk assessment tools is a core concern of forensic psychology and psychiatry. This paper introduces themes and approaches picked up elsewhere in SAANZ for example, Ogloff & Doyle (2009), Proeve (2009), Lennings, Seidler, et al., (2011).
	(2) Merdian, Jones, Morphett, & Boer (2008). The paper discusses the assessment of sexual deviance utilising phallometry. It raises ethical, professional and technical concerns with the use of phallometry and presents a challenge to the reader as to how to reliably and validly assess sexual deviance. Paper type: Scholarly review.	The assessment of sexual deviance is another core issue in predicting recidivism and targeting treatment for sex offenders. How to do that in a reliable, valid and ethical way remains a concern. Research is required to identify acceptable methods of quantifying what is deviant. To date, attempts to establish biological measures, questionnaire measures and behavioural analysis are all bound by limitations. The fundamental concern of deviance to offending remains a fertile area of future research.
	(3) Proeve (2009). This paper sets out to identify a minimum number of items to form a scale to	The paper outlines a methodology available to clinicians working in treatment and assessment

	predict recidivism or sexual offending in participants to a treatment program, not all of whom are adjudicated sex offenders. The task Proeve sets for himself is the development of a scale that can be used in the absence of good information, such as often occurs in civil cases and where instruments, such as the Static 99 may not apply or can't be used. Paper Type: Empirical research with parametric analysis.	programs. In this paper file review of 300+ offenders accessing community based treatment services are used, including clients without convictions. The paper is a good model for data mining of existing records.
	(4) Merdian, Wilson, & Boer (2009). Only one paper has been submitted to SAANZ exploring internet offenders. Given the rapid increase in interdiction and sentencing of such offenders, it is puzzling why there has been so little interest in this area amongst our contributors. This paper essentially profiles what is known about Internet Sex Offenders and draws some important parallels but also reveals some important differences between internet and contact offenders that has implications for treatment. Paper Type: Scholarly review – meta analytic style.	The paper provides a wealth of profile-little information on internet offenders that allows for testable hypotheses leading to pathway analysis approaches. The paper reviews 17 investigations into internet offenders to identify characteristics that might parallel or differ between internet and contact offenders, and provides preliminary data that should refine the development of assessment approaches to internet offenders. Importantly, it raises the need to be careful about not simply transferring treatment strategies developed for contact offenders onto internet offenders. As a consequence it throws down a challenge to develop a sophisticated understanding of the treatment needs of internet offenders as opposed to contact offenders.
	(5) Reid, Wilson, & Boer (2010). The paper explores the Massachusetts Treatment Center rapist typology, developed as a classification system for assessment of sex offenders. A critical issue raised by the authors is that the purpose of a typology is to help orient treatment and serve as a guide in risk assessment. The study was a small sample pilot to determine the reliability and applicability of the typology to New Zealand offenders. Paper type: Empirical research, small sample pilot study.	The study provides an example of the application of carefully considered small sample approaches to testing the feasibility of larger, resource intensive research. It demonstrates the advantages of working in a system in which comprehensive, standardised measures and information are available and allows data mining studies.
	(6) Nisbet, Smallbone, & Wortley (2010). The study is part of a larger research effort investigating juvenile sex offenders, and the only paper published in SAANZ on juvenile offenders. Like the paper before it, the study is an example of data mining of assessment material collected as part of a treatment program. The study explored the "versatile" / "specialist" offender, providing good information about differential factors acting on some juvenile offenders. Paper type: Empirical research with parametric analysis.	The research reinforces the value of a thoughtful approach to collecting data, and providing thereby opportunity for substantial research activity through careful examination of the data. In the process information that helps guide treatment approaches, risk assessment and prevention programs is gained.
	(7) Lennings, Seidler, Heard, Collins, & Nasr (2011). The paper sets out to compare the Static 99 and the revised version, the Static 99R. It reports a psychometric evaluation of the two scales in a convenience sample collected as part of	The paper reveals the advantages through collaborative research between clinicians and academics (providing the statistical grunt sometimes lacking in clinicians). It demonstrates the opportunities available for practitioners through

	routine assessment for court evaluations. The paper reflects issues raised by Smallbone & Wortley (2008). Paper Type: Empirical research with parametric analysis.	their usual professional activities.
Ethical and Professional Issues	(1) D. Boer (Editorial, Vol 1 (2) 2009). This editorial takes clinicians to task on their role and responsibilities of being an expert witness.	
	(2) Ogloff & Doyle (2009). It is hard to know whether this paper belongs in the professional and ethical issues or in the offender assessment section. The paper is a comprehensive review of the critical issues facing experts giving evidence on risk assessment and takes to task complacency in risk assessment, and outlines the risks and limitations of risk assessment. Paper type: Scholarly review.	The paper is one of a series of papers in SAANZ exploring ethical, practical and professional issues around risk assessment (e.g., see Smallbone & Wortley, 2008; Lennings, Seidler et al., 2011). The paper advances concerns that need to be taken up in future research, such as the establishment of base rates for offending, AUC ratios for risk assessment tools, and explores these issues in the new world of post-sentence legislation. It thus enters the policy debate. The paper also challenges clinicians to brush up on the knowledge of statistical theory, as the paper relies heavily on clinicians understanding concepts such as type 1 and type 2 errors, base rates, etc.
	(3) Lennings (2009). What began as an editorial developed into a review of ethical dilemmas for the clinician working in the fields of treatment and assessment. It considered the notion of the hired gun, and advanced an ethical model for the clinician to evaluate their behaviour. Paper type: Review and case study.	"Hired guns" may or may not exist but the perception that they do is strong. How can clinicians arrive at different viewpoints from the same data? The paper explores the pressures acting on clinicians to arrive at a formulation that may be kind to a client or referring agency, and proposes a critical method for the clinician to evaluate his or her performance. The paper can be read in conjunction with D. Boer's editorial (Vol 1 (2), 2009) and provides a method that can be evaluated and tested by clinicians wishing to engage in collaborative research.
Theory development	(1) Yates & Ward (2008). The paper outlines and integrates Ward's theory of the Good Lives Model and the Self Regulation Model. The paper discusses the application of these models to offender management, and engages with public policy debates about the development and type of treatment programs that should be available for offenders. Paper type: Scholarly article.	The critical aim of the GLM is to enhance therapeutic outcomes for offenders. To the extent that research can clearly formulate the intervention strategies derived from the theory, and evaluation can establish their effectiveness, the theory receives validation. Challenges for professionals in our area is to work in programs that may incorporate the GLM approach, and produce evaluations of it, compared to "standard" Relapse Prevention and Risk/Responsivity programs.
	(2) Huang, Hsu, Beech & Wu, 2009. This paper sets out to explore both the relapse prevention pathway model, and also implicit theory in a Taiwanese group. It extends approaches developed in Western contexts into a culturally different society. The research both supports the pathways model promoted by Ward and also cross cultural support for offence related schemas. Paper type: Empirical research with non-parametric analysis.	The paper is a good model for the development of basic research into testing models and theories of sex offender related cognitions and behaviours. It builds on the construct validity of the implicit theory approach, providing valuable data to tailor treatment approaches to offenders.

	(3) Bartels & Gannon (2009). This paper explores fantasy and rape myths testing the Implicit Theory model of Ward. It also reflects the concerns raised in Merdian et al., 2008 about the role deviant fantasy may play in supporting offence specific behaviour. It utilises lexical recognition task methodology found in cognitive psychology as a test of underlying impact theory. The research identifies the prevalence of offence related fantasy in offenders, but did not support the notion that such fantasies were a product of related implicit theories. Paper type: Empirical research with parametric analysis.	This paper provides a sophisticated methodology for testing theoretical developments proposed to account for offender motivation. Along the way it raises important opportunities for examining the relationship between deviant fantasies, coping mechanisms and underlying schema or motivational sets that might be used to explore why offenders offend and what can be done to reduce recidivism. The exploration of fantasy and possible underlying schema (Implicit theories) remains an important research area in both theory building and treatment (e.g., Huang et al., 2009; Yates & Ward, 2008). Replication is a critical aspect of validity, and the development of sophisticated methods of exploring the underlying mechanism of offending behaviour leading to improvements in treatment is an important contribution to minimising harm to society from sex offending.
	(4) Marshall, Marshall, & Ware (2009). This paper takes to task the development of broad approaches to cognitive distortions, schemas and scripts. It argues care must be taken to identify those cognitive distortions that are related to criminogenic needs and offending, and not to attack distortions that might have no established criminogenic relevance, but look bad, such as denial and minimisation. The approach argued has major implications for how offenders may be excluded from treatment, as well as the type of treatment that may be beneficial with offenders (and harmful). Paper Type: Scholarly review.	The paper sets out a series of testable hypotheses about the impact of treatments designed to attack various cognitive distortions. It raises important ethical and professional debates about the provision of treatment to people who minimise or deny, given Marshall et al's argument (and strong evidence) that such a proclivity is unrelated to recidivism (a claim that seems to oppose common sense). The paper reflects concerns raised by Winship, Straker & Robinson (2011) and explored empirically by Prately & Goodman-Delahunty (2011). The exploration of non-criminogenic distortions as well as criminogenic ones (such as implicit theories) remains an intriguing area of research.
	(5) Jones & Vess (2010). The paper sets out to further explore the notion that distorted cognitions (Implicit theories) have a role to play in understanding sex offending. The paper argues for the central role cognitive distortions play in the motivation for offending, and hence the importance of tapping such cognitions for treatment. Given the often observed finding that child molesters have traits of varying personality disorders, the paper extends the theory by exploring the role cognitive distortions may play within a framework of personality disordered clients. Paper type: Small sample empirical research with parametric analysis Boer (2011) Editorial. The editorial deals with the upcoming DSM V and suggestions for changes in the paraphilia diagnosis to, in effect, include a classification that captures rape behaviour. The contentious aspect of this approach is discussed.	The study is an example of correlational research useful in theory building, and helpful in gaining support for therapeutic interventions. It is the kind of study that is suited to clinicians who are thoughtful in their choice of test material and have access to clinical samples and fits into an action research format as easily as it does into experimental research. For those involved in long-term treatment of clients, the methodology also provides a ready made treatment evaluation model.
	(6) Winship, Straker, & Robinson (2011). Vol 3. The study sets out to review what is meant by denial and minimisation and provides an analysis of this through review of treatment notes of clergy	At several places in this review of papers the importance of keeping good records as a precursor to undertaking research has been discussed. The current study is a clear example of the value of

	in treatment for sexual offending. The paper is a detailed analysis of what is a vexed issue in sex offender treatment with differing views as to the role denial or minimisation may play in predicting recidivism, as a treatment target, or as a disqualification for treatment. Paper Type: Empirical study with qualitative data.	combining a good data collection with an interesting question derived from a knowledge of the literature, and along the way raising important issues for therapeutic efforts with offenders.
Public Policy Issues	Vess (2009). In this paper James Vess extends his 2008 offering and explores the policy debate about extended supervision/preventative detention laws through a comparison of New Zealand and United States legislation and outcome studies. Echoing the concerns raised in his earlier paper (Watson & Vess, 2008) and following directly on from Ogloff and Doyle (2009) he explores the legal, political and professional issues involved with such legislation. Vess distinguishes between extended supervision and preventative detention, finding the former appropriate within a cost benefit approach to protecting society. Paper type: Scholarly review. Seidler (2010). It was hard to know where to place this study. It is both a study of what policy makers can learn about the impact of policies on offender management and monitoring, as well as providing insights into offender management. However, the strong voice given to offenders seems best to lie here, as without considering the impact of policy measures on those the policy is intended for, paradoxical (and unwanted) outcomes can be achieved. This paper should be read in conjunction with Watson & Vess, 2008; Willis, 2010; and Vess, 2009. Paper Type: Qualitative research.	The policy debate and how to protect society from "sexual predators" remains a controversial issue. Research can address these issues through follow up studies (e.g. Watson & Vess, 2008); offender perspectives (Seidler, 2010); empirical research on the effectiveness of risk assessment tools (e.g., Smallbone & Wortley, 2008). What is missing from SAANZ are voices from survivors and families (not that the Editors have not tried to have such articles submitted). There are many levels readers can contribute to in this debate, and given the importance of it, contributions are needed. The paper reflects the research potential that exists in thoughtful listening to our clients. It needs to be complemented by similar research with victim/survivors, policy makers and treatment providers to expand our knowledge of how current policy settings impact on the goal of reducing offending and recidivism. The paper explores opportunities to enhance community based offender therapy and provides a rationale for expanding research in this area.

et al., (2009) as to what is a salient or criminogenic distortion and what is not admits of much further research, as does whether distortions exist as causative elements at all.

One of the most important contributions to offender assessment and treatment has been the Good Lives Model (Yates & Ward, 2008). What is desperately needed are submissions that have operationalised this model and evaluated the impact of it compared to the standard Relapse Prevention and Risk Needs and Responsivity (RNR) (Andrews and Bonta, 1994) models currently in vogue. As might be expected, treatment evaluations, advice on treatment and research into building offender profiles are strong themes in our journal. Continued work is needed in the area of validity research into offender risk assessment instruments and profiles, and in particular how they may apply to special groups in Australia and New Zealand, including Indigenous populations, women and young people. Given the debates about the modification of the Static 99 and Static 99R, further research into how age may affect risk prediction, offender management, and treatment is required.

What is surprising is the paucity of research into internet offenders (only one submission: Merdian et al, 2009). It is thought that internet offenders make up to one third of current offenders presenting for assessment, there remains considerable debate about the use of risk assessment approaches to that group (what does an effective risk assessment for an internet offender look like?) and whether internet offenders benefit from the same kind of treatment approaches currently used for contact offenders. The need to expand what we know about internet offenders in terms of assessment, treatment, management and theory building is evident, and a fertile ground for further research.

We are also surprised by the absence of submissions on juvenile offenders (only one study: Nisbet et al., 2011). Although there have been challenges to the notion that many sexual offenders begin their offending in their teenage years, early onset offending is regarded as a significant risk factor. Given the focus on rehabilitation for young offenders, it seems necessary to explore what is known about young sexual offenders in Australia and New Zealand. In Australia, there has been a change in the way young offenders who offend against family members have been treated with more use of civil than criminal courts (e.g. the use of Apprehended Violence Orders). Evaluation of the effectiveness of such a change and the kinds of treatments, supervision, and family responses to such civil as opposed to criminal interventions appears necessary and we would welcome submissions around such issues.

Both Ogloff and Doyle (2009), and the contributions of Vess (Jones & Vess, 2009; Watson & Wess, 2008; Vess, 2009) explored the policy issues around extended supervision/preventative detention. Given the importance of civil rights to such legislation, as well as debates over how to effectively measure "dangerousness", research into this area of offending seems required. Recent proposals to extend such legislation to include violent offences raise concerns about how the policy has worked. Seidler's (2010) qualitative study into the impact of current offender management practices on offenders needs to be matched by similar studies with survivors and their families so a full appreciation of how such controversial legislative responses in the community can be obtained.

There are no submissions on issues to do with victim/survivors of sexual abuse. It remains a critical issue in the field that victim issues are well understood. ANZATSA has always sought to balance the focus on offenders with an understanding of what the abuse means for survivors, their family, and society in general. Papers exploring psychological impacts, treatment responses and policy issues around the role of victim impacts on offender release, family unifications, and diversionary programs are of great interest. In intrafamilial offences, clinical practice often has to deal with the consultative process between the offender's therapist and treatment goals and the victim's therapist and treatment goals. How that may be happening, and what kinds of strategies might be employed to improve inter-professional communication, are topics worthy of exploration that have yet to surface in submissions.

There were no submissions on female offenders even though over the last two decades there has been slow growth in the reporting of female offenders, and the beginning of research into female offender profiling and risk assessment. Only one paper considered cultural issues (Hansen-Reid, 2011) and the need to consider how assessment and treatment technologies may impact on culture are topics that should be better explored, especially in the Australian and New Zealand communities. There are thus important gaps succeeding editors might seek submissions on.

The lessons learnt through this review are clear. Research can be usefully undertaken by those practitioners who, as a matter of course, keep good records, use standardised assessment procedures, keep up to date with theoretical and professional developments, and are thoughtful about their clients. The research reported in the first three volumes of SAANZ reflects multiple types of research and multiple types of researchers. The role collaboration plays between clinicians, between clinicians and academics, and between clinical services, is crucial to good research.

Research methodologies span the range, including empirical studies, scholarly reviews, qualitative research and case studies. Fewer qualitative studies were published than expected (only two not counting the two case study submissions). Given the importance qualitative research can have for raising hypotheses, more papers of that kind could be submitted in a journal that has as its focus applications of theory and practice. Potential authors might want to consider the advantages that a mixed method research design provides: in which a large-scale study reports quantitative study followed up by qualitative research to enrich the meanings of the statistics. Research strategies for small samples can also make use of descriptive and non-parametric analyses. In Australia and New Zealand, we are often faced with small samples (especially treatment samples) and there are difficulties in maintaining contact with participants after mandatory supervision periods have elapsed. Hence, it is difficult to undertake large studies and longitudinal studies except for those that work in government funded instructions. However, ethics committees and political concerns can limit the range of research possible within large institutions. None the less, without a strong commitment to both research and the dissemination of research findings, the work we do cannot develop.

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What's the Buzz? Bumblebees – A Therapeutic Preschool for Abused Children

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Abstract

Early childhood experience of maltreatment (including neglect, sexual, physical and/or emotional abuse) is well documented as a risk factor for a number of adverse psycho-social outcomes and confers a high risk for life-long impairment across a range of domains. However, there is some research which indicates that early therapeutic intervention (particularly trauma-focused Cognitive Behavioural Therapy programmes combined with supportive and/or psychodynamic therapies) can mitigate these ongoing effects. The current study examines the outcome of a therapeutic preschool (Bumblebees Therapeutic Preschool – BTPS) for 65 children ranging in age from three to six years of age. Child and family resiliency (suggested as a protective factor against further harm – measured via the Clinical Assessment Package for Risks and Strengths), sexualised (Child Sexual Behavior Inventory) and maladaptive behaviours (Child Behavior Checklist) were measured via Parental/Caregiver report at Intake and Exit of the programme. Analyses demonstrated statistically and clinically significant reductions in problematic behaviour (both sexually-oriented and general) and significant improvement in resiliency scores. The contribution of specific demographic factors such as witnessing family violence, being of Indigenous descent and gender are discussed.

Introduction

The importance of early childhood therapeutic intervention programmes is highlighted by the fact that the first few years of a child's life are crucial to setting the foundation for further development in key areas such as lifelong learning, behavior and health outcomes (e.g., Gilbert, Spatz Widom, Browne, Fergusson, Webb & Janson, 2009). A plethora of research exists cataloguing the multiple, lifelong impairments in these areas that can result from early childhood experience of sexual and/or physical abuse (e.g., Cougle, Timpano, Sachs-Ericsson, Keough & Riccardi, 2010; Doerfler, Toscan & Connor, 2009; Lalor & McElvaney, 2010) as well as research which details the negative effects resulting from growing up within a violent or neglectful home environment (Richards, 2011) with or without direct abuse (White & Widom, 2003). Research also indicates that therapeutic intervention, especially at a young age, can mitigate many of the socio-emotional and mental health sequelae associated with such adverse experiences (see Sánchez-Meca, Rosa-Alcázar & López-Soler 2011 for a meta-analysis of treatment approaches and outcomes).

Focusing on early intervention and prevention is individually, socially and economically more effective in the long term. That is, it would seem more effective to prevent the occurrence of problems early in life rather than deal with problems that have become entrenched and that may escalate to secondary problems in adulthood. For example, many studies have highlighted the increased risk for sexual re-victimisation following experience of abuse as a child (e.g., Lalor & McElvaney, 2010) while others have highlighted the increased prevalence of Post-Traumatic Stress Disorder (PTSD; e.g., Cougle et al., 2010), depression and anxiety and related impairments to socio-emotional functioning, educational opportunities, and physical health following the experience of sexual abuse in childhood (e.g., Dube, Anda, Whitfield, Brown, Felitti, Dong & Giles, 2005; Lalor & McElvaney, 2010). In addition to impacts on individuals, sexual and physical abuse of children affects society as a whole (Gilbert et al., 2009). Various authors have suggested that working with victims to reduce the possibility of further victimisation or themselves becoming perpetrators of antisocial behaviour and/or abusive and neglectful treatment of their own children (Goldman & Padayachi, 2000; Simons, Wurtele & Durham, 2008; Wurtele, Moreno &

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Kenny, 2008) benefits the community immediately and in the long term.

Prevalence of child abuse in Australia

It is generally accepted that there are four types of child abuse (often referred to as child maltreatment). These are physical abuse, sexual abuse, emotional/psychological abuse and neglect (Lamont, 2011). Determining the exact prevalence of child abuse is next to impossible due to reporting and data collection difficulties. The only official statistics about abuse are derived from reports made to statutory child protection departments. The fact that these numbers do not reflect the true extent of child abuse has been commented on by numerous authors who point out that many cases go unreported (e.g., Gilbert, et al., 2009; MacMillan, Jamieson & Walsh, 2003). The current project examines data from children entering a therapeutic preschool in regional Queensland, Australia, from 2002 to 2008. Official data from this period indicates that there were 198,355 reports of suspected child abuse made to state authorities across Australia during 2002-2003 and 317,526 reports made during 2007-2008, reflecting the general increase in abuse notifications. These resulted in 40,416 and 55,120 substantiated cases respectively. Within these reports younger children (i.e., < 12 months and 1 to 4 years) were more likely than older children, and Indigenous children (Aboriginal and Torres Strait Islander) were more likely than non-Indigenous children, to be the subject of a substantiated report (Lamont, 2011). In a discussion of the prevalence of substantiated abuse types reported to authorities in 2009-2010, Lamont (2011) noted that emotional/psychological abuse was the most prevalent, followed by neglect, physical then sexual abuse. Importantly, he noted that children exposed to domestic or family violence are now officially included within the 'emotional abuse' category and that may be the reason for the increase in substantiated emotional abuse cases seen in recent years. Surveys have estimated children witness violence within 30-50% of families where family violence is occurring in Australia (Mouzos & Makkai, 2004). This percentage may be higher within Indigenous families, and/or within those living in regional or rural areas given the over-representation of both demographic characteristics in family violence statistics nationally (e.g., Indermaur, 2001; Mouzos & Makkai, 2004).

As is increasingly being acknowledged, growing up within a violent home (and this includes witnessing violence without being directly targeted) can result in numerous adverse psychological and socio-emotional outcomes. These include PTSD, depression, empathy deficits, alcohol and drug abuse and an increased risk for the continuance of the 'cycle of violence' (Duncan, Thomas & Miller, 2005; Simons et al., 2008; White & Widom, 2003). Researchers have estimated that the risk of experiencing other forms of maltreatment, given witnessing family violence as a child, is between 30-50% (Appel & Holden, 1998; Herrenkohl, Sousa, Tajima, Herrenkohl & Moylan, 2008). Thus, a family history of violence must be taken as an indicator for increased risk for further abuse. In a recent examination of children's exposure to domestic violence in Australia, Richards (2011) stated that there is an urgent need to research and evaluate programmes that address the issues presenting in children from violent homes.

It must be noted that not all children who experience maltreatment develop serious sequelae (Afifi & MacMillan, 2011; Jaffee, Caspi, Moffitt, Polo-Thomas & Taylor, 2007). Many children 'cope' with adverse living environments even though they are at a high risk for developing behavioural and mental health problems. This form of coping is often attributed to resilience and is one of the strengths that children coming out of abusive or neglectful family environments may bring with them (e.g., Afifi & MacMillan, 2011). The term "resiliency" is used to describe "a set of qualities that foster a process of successful adaptation and transformation despite risk and adversity" (Bernard, 1995, p.1). A resilient child according to Gilligan (2000) is able to 'bounce back' from adverse experiences. Researchers have identified a number of individual, family and community level resilience factors – often termed protective factors – that protect against negative outcomes. In a review of the literature, Affifi and MacMillan (2009) reported that family-level characteristics such as a stable care giving environment, and at least one supportive (non-offending) caregiver, were the factors most consistently related with high resilience following childhood maltreatment. At an individual level, gender (girls compared to boys) and personality traits (e.g., ego control, internal locus of control etc) but not intelligence were reported to relate to better resiliency following maltreatment. Community factors such as peer influences, certainty of schooling, stable relationships with nonfamily members have been shown to relate to better resilience. Afiffi and MacMillan note however that there is a relative paucity of research examining community level resilience factors. Related to this, Gilligan (2000) described resilience as being a quality of both the individual and their social surroundings, suggesting that attempts to boost resilience should focus not only on the child's strengths but also on their family and social environment. Developing, strengthening, and evaluating the resilience of the children and families participating in the project was therefore one of the core aims of the current research on the Bumblebees Therapeutic Preschool (BTPS).

The rationale for the BTPS approach stems from a large and growing body of literature that explores the impact of early trauma on attachment and also draws from research in the area of resiliency. It is beyond the scope of this paper to comprehensively outline the theoretical underpinnings of Attachment Theory and its relation to childhood maltreatment (for a review and meta-analysis of this see Baer & Martinez, 2006) but in brief, Attachment Theory suggests insecure attachment, which in turn is a marker for later social and emotional problems, is a likely outcome of abusive familial dynamics (Bacon & Richardson, 2001; Morton & Browne, 1998). A substantial body of research suggests that insecure attachment is linked with a higher propensity for antisocial and/or abusive behaviours including coercive (non-criminal) and abusive/criminal sexual behaviour (e.g., Smallbone & Dadds, 2000), generalized aggression (e.g., Lyons-Ruth, 1996) and a heightened risk for maltreatment of offspring (e.g., Bacon & Richardson, 2001).

In contrast, numerous studies have demonstrated that support from a non-abusive parent or carer is a good mediator of the effects of abuse (Ambridge, 2000; Hemenway, Solnick & Carter, 1994). Dimitrova et al. (2009) in fact suggest that the clinical consequences of childhood abuse (particularly sexual abuse) may be directly related to the quality of the individual's attachment experiences both before and after the abuse. Attachment theory thus offers a framework for understanding and responding to the developmental effects of abuse and neglect, and has significantly informed the BTPS aim of promoting not only a more secure sense of self for children but also for their adult parents and/or caregivers. These adults are included in the BTPS in order to promote stable, secure, attachment and increase their own resiliency.

The BTPS programme was established in 2003 and provides assessment, therapy and education for children aged three to six years who have been either harmed, are at risk of harm, or who are exhibiting harmful behaviours and was designed as an early intervention and prevention preschool initiative. The BTPS also provides counselling and support for the parents/caregivers and families of these children. The programme was adapted from the model used by the Kempe Therapeutic Preschool (Denver, Colorado) by the first author (KP) for the Australian context. The BTPS incorporates therapy and group work within a preschool setting for up to nine children at any one time. A high staff:child ratio is maintained at all times and each child, the child's family, and their needs are individually assessed. A manual for the BTPS is available from the first author (KP). The BTPS programme provides assessment and therapeutic interventions within a structured preschool setting. When a child attends the BTPS, part of their participation includes up to one hour per fortnight of individual therapeutic counselling. This is usually provided in the preschool setting in smaller, 15-20 minute timeslots. Weekly counselling is also provided for parent/caregiver, and sessions are run jointly with the child/parent, and some with the child or parent alone. The BTPS social worker provides therapy in situations that the adult client feels most at ease (e.g., at home, in the office and/or with the child at the preschool).

A combination of therapies are utilised including play therapy (which works integratively using a wide range of play and creative arts techniques), and developmentally appropriate trauma-focused cognitive behavioural therapy (TF-CBT). A recent meta-analysis of studies examining psychological treatments for sexually abused children concluded that TF-CBT programmes combined with supportive and/or psychodynamic therapies (such as the play therapy utilised in BTPS) resulted in the best improvements in functioning (Sánchez-Meca et al., 2011). The authors of the meta-analysis also noted the need for careful assessment of functioning across a wide range of aspects given the variety of symptoms that children can display following abuse; they specifically recommended the use of the Child Behavior Checklist (CBCL; Achenbach, 1991) to assist with this.

The BTPS is located in Bundaberg, a regional area approximately 350km north of Brisbane with a population of around 48,000 (ABS, 2006). The Socio-Economic Index of Disadvantage for Bundaberg (calculated from the 2006 census and comparing demographic indices such as income, education and unemployment) was skewed to the lowest quintile with 49.2% of residents falling in the 'most disadvantaged' category (ABS, 2006). Lower educational attainment, single parent families and unemployment (as related to lower income levels) are all acknowledged risk factors for increased parental/caregiver stress, lower levels of resiliency and child maltreatment (e.g., Campbell-Sills, Forde & Stein, 2009; Gilbert et al., 2009) and the Bundaberg area has a disproportionately high prevalence of families with these risk factors compared to other locales of similar size in Queensland.

The BTPS programme has two aims. First, to increase the resiliency of the children (and parents) attending the programme via individual and social resilience factors such as social competence, problem-solving skills, autonomy, and the ability to establish a close bond with appropriately responsive adult(s) and caring peers/friends. In the current paper, this aim was examined via Clinical Assessment Package for Risks and Strengths (CASPARS; Gilgun, 1999) Intake and Exit scores. The second aim was to address (or alleviate) the children's symptoms of psychopathology and problematic behaviour following maltreatment. As

recommended by Sánchez-Meca et al. (2011), this second aim was evaluated by examining Intake and Exit scores on both the Child Behavior Checklist (CBCL) and the Child Sexual Behaviour Inventory (CSBI). For ethical reasons, it was not appropriate to evaluate the treatment efficacy of the BTPS using a standard control vs experimental group design (a common problem with studies looking at efficacy of treatments for abuse, Sánchez-Meca et al., 2011) and the approach suggested by Cooper, Hedges and Valentine (2009) was utilised instead. That is, the entire group was taken as the 'analysis unit' and effect sizes were determined by comparing intake and exit mean scores divided by the standard deviation at intake.

Method

Participants

Information was collected from the parents/caregivers of 72 children entering the BTPS from 11/11/02 to 12/12/08, all children were aged between three and six years at intake and the majority attended two days a week. Data cleaning and verification of missing data resulted in 65 individual cases for analysis (38 girls and 27 boys). Presented in Table 1 is a summary of the major demographic characteristics at intake. As can be seen in the Table 1, 82% of the children had witnessed some form of family violence and nearly half had experienced sexual assault/abuse. Six of the children who completed the BTPS were of Indigenous descent, approximately 9% of the total number of children in the current sample (according to the 2006 Census persons of Indigenous descent account for approximately 3% of the population of the Bundaberg area). Nearly 75% of the primary caregivers had a secondary school level education with a further 20% holding a Trade Certificate or Diploma. Seventy percent of the primary caregivers were unemployed, and 52% were single parents/caregivers, at the time their child was attending the BTPS.

Table 1. *Summary of major intake characteristics*

Variable	Yes	No
Care & Protection Order (C&P)	18	47
Witnessed family violence (FV)	53	12
Sexual Assault (SA)	31	34
Aboriginal or Torres Strait Islander (Indigenous)	6	59
Average number of days/week	1=9	2=56
Gender	M=27	F=38

Apparatus

Clinical Assessment Package for Risks and Strengths - CASPARS

CASPARS (Gilgun, 1999) is for use with families and children where the children may have adjustment issues (Gilgun, 2004). An overall (total) score, and scores on five sub-scales; Family & Child Community Relationships [Embeddedness], Emotional Expressiveness [Expressiveness], Family Relationships [Family], Peer Relationships [Peer] and Sexuality can be calculated. Test re-test reliabilities and alpha coefficients for CASPARS are reportedly high (Gilgun, 2004), and were high in the current data (Total scale, Cronbach's alpha = 0.912) indicating good clinical utility.

Child Behavior Checklist – CBCL

The CBCL is a caregiver report questionnaire used to rate levels of maladaptive, social, emotional and behavioural problems in pre-school children (Achenbach, 1991). Specifically, it can be utilised to indicate levels of Internalising (anxious, depressive, and over controlled) and Externalizing (i.e., aggressive, hyperactive, noncompliant, and under controlled) behaviours as well as a total problem score. Total T scores under 60 indicate 'normal' levels of behaviour, 60-63 borderline and T scores greater than 63 indicate clinical levels of behaviour where intervention is needed. The reliability measure (Cronbach's alpha) for the current data set was high ($\alpha = 0.828$).

Child Sexual Behavior Inventory – CSBI

The CSBI (Friedrich, 1998) is 38-item caregiver report measure of sexual behaviour in children, it is only intended for use with children who have either been, or suspected to have been, sexually abused. Three clinical scales can be derived from the CSBI; the *CSBI Total* scale - overall level of sexual behaviour exhibited, *Developmentally Related Sexual Behaviour* (DRSB) scale - sexual behaviours that are normative for child's age and gender, and the *Sexual Abuse Specific Items* (SASI) scale – sexually related behaviours that are atypical for child's age and gender. From a clinical perspective, CSBI Total *T* scores above 65 indicate symptomatology in need of clinical intervention (Friedrich, 1998). As these scores were collected as summative scores, it was not possible to calculate a Cronbach level for the CSBI.

Procedure

At intake (prior to the child commencing the BTPS) each parent/caregiver is given a series of forms/questionnaires to fill in, these include the CASPARS, CBCL and CSBI reported here. Consideration was given to families with specific

needs. For example families identifying as Aboriginal and Torres Strait Islander were interviewed with the Aboriginal and Torres Strait Islander Family Support Worker and parents with an intellectual disability were provided with assistance in reading the questionnaires. At exit these same questionnaires were filled in again.

Results

Families attended the BTPS for an average of nine months (range 1 to 22 months) with no significant difference in length of time within the BTPS by presenting characteristics; 'Care and Protection Order' [C&P], 'witnessed family violence' [FV], 'experienced sexual abuse' [SA] or Indigenous descent. Although more girls than boys attended the BTPS (see Table 1) and more children attended for two days per week than one day, when this pattern was examined in more detail, it was found that although girls spent significantly more time within the service on average (average total hours = 151 for girls; 102 hours for boys, $t_{(65)}$=-2.761, p=0.007) this was not due to being in the BTPS more days per week. Indeed boys were more likely than girls to attend for two days per week, and although not statistically significant, attending for two days appears to be related to a shorter overall stay within the BTPS (i.e., fewer months between Intake and Exit). This correlation holds (although not significant) once gender has been controlled for (r=-0.113, p=0.368) and suggests that attending the BTPS for two days, rather than one, per week may be more effective. However given the large discrepancy in group sizes this finding should be interpreted with caution.

Impact of the BTPS on Resiliency (CASPARS)

Overall (total) CASPARS scores improved significantly from Intake to Exit with the average Intake score being 30.4 and the average Exit score 128.7 (t(56)=-13.648, sig = 0.000), absolute effect size (otherwise known as the "treatment effect") was calculated to be 1.44 which is a large effect according to Cohen (1988). As can be clearly seen in Figure 1, girls entered (44.8 vs 10.6), and exited (147.6 vs 44.8), TPS with higher total CASPARS scores than boys – a disparity that was magnified (and significant) at Exit. The cause of this is unclear and merits further study given that females have been reported to be lower in resiliency overall (e.g., Campbell-Sills et al., 2009).

Presented in Table 2 are the average CASPARS scores for each of the five subscales by major characteristic. Indigenous status had no differential effect on Intake or Exit scores. Of the other characteristics, children having experienced sexual assault scored dramatically lower at Intake compared to those who had not been sexually abused, however this difference was not present at Exit. Care and Protection (C&P) status was related to a significant difference on the Emotional Expressiveness ($t_{EXPRESSIVENESS}$(62)=-2.628, sig = 0.011) and Peer Relationships (t_{PEER}(24)=-2.216, sig=0.036) subscales. For both, children currently under a C&P scored lower (and more negatively) than those not under a C&P order. Witnessing Family Violence (FV) was related to significantly different scores on Embeddedness ($t_{EMBEDDEDNESS}$(62)=-3.093, sig=0.003); Family Relationships (t_{FAMILY}(62)=-4.604, sig=0.000) and Total CASPARS scores (t_{TOTAL}(62)=-2.827, sig=0.006) at Intake. Unlike the previous characteristics however, these differences remained significant at Exit. For all three, children who had witnessed FV scored substantially lower than those who had not. Although scores on all of the CASPARS measures improved significantly for children who had witnessed FV, they remained at a lower level than the rest of the children exiting the BTPS.

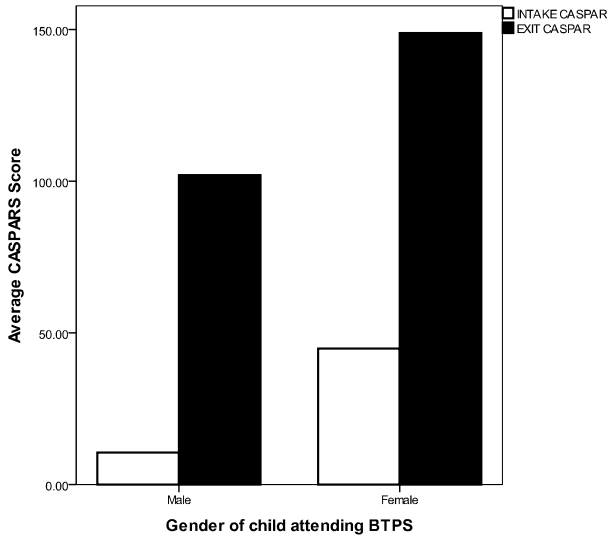

Figure 1. *Average CASPARS intake and exit scores by gender of child attending the BTPS*

In an attempt to further clarify the differential effects of the major intake characteristics on this primary measure of resiliency, a stepwise linear regression was performed. Total CASPARS (Exit) scores were loaded as the dependent variable and Gender, C&P, FV, SA and Indigenous characteristics were entered as independent variables. Only FV and Gender proved to load in the subsequent model explaining nearly 24% of the variance in Total CASPARS scores (adjusted β weights 0.309 and 0.274 respectively). That is, only Witnessing Family Violence and Gender significantly predicted CASPAR scores.

Table 2. *Average CASPARS score by major characteristic*

	GENDER		**C&P**		**FV**		**SA**		**Indigenous**	
	Male	Female	Yes (n=18)	No (n=11)	Yes (n=51)	No (n=44)	Yes (n=28)	No (n=34)	Yes (n=6)	No (n=56)
	Intake/Exit	Intake/Exit	Intake/Exit	Intake/Exit	Intake/Exit	Intake/Exit	Intake/Exit	Intake/Exit	Intake/Exit	Intake/Exit
Embeddedness	-0.3/19.2	11.1/28.5	6.6/28.6	21.3/34.6	4.1/22.2	7.4/22.7	3.4/22.9	10.3/25.6	2.3/23.7	7.7/24.5
Expressiveness	-5.0/15.0	1.0/27.2	-10.0/18.8	0.4/33.5	-1.8/20.0	2.1/23.9	-2.8/24.3	-0.3/20.8	0.2/22.0	-1.6/22.4
Family	-2.1/20.4	12.3/29.5	7.5/30.4	28.2/36.3	2.5/23.2	6.9/23.5	8.0/25.3	6.3/25.8	-6.0/23.0	8.5/25.8
Peer	5.4/23.3	9.6/33.1	-1.6/25.8	14.5/36.7	6.8/27.5	12.1/30.5	6.5/30.4	9.4/28.1	9.5/32.3	8.0/28.8
Sexuality	3.6/26.4	9.8/33.2	3.3/30.2	14.5/38.1	5.6/29.2	8.8/31.0	0.9/29.3	12.4/31.9	9.7/32.2	6.9/30.6
Total	10.6/102.1	44.8/147.6	21.4/129.9	80.6/181.1	22.3/121.0	37.3/132.4	15.9/131.9	46.5/131.5	17.3/133.2	34.3/131.5

Impact of the BTPS on symptoms of psychopathology and problematic behaviour

Child Behavior Checklist (CBCL)

At Intake, 39 children (57% of those attending BTPS) had CBCL Total T scores within the clinical range, a further 10 (15%) had scores within the Borderline range, thus more than 70% of those attending BTPS had serious, problematic, behaviour that required intervention and treatment. Although at Exit 17 children (25%) still recorded clinical levels of maladaptive behaviour (CBCL Total scores), nearly 70% (n = 46) had CBCL Total T scores well within the 'normal' range for children this age, the effect size of this change (in Total T scores) was 1.1, a large effect. Presented in Figure 2 below are the CBCL Total T Scores differentiated by gender. The horizontal lines at 60 and 63 indicate the upper limit of 'normal' behaviour and the level at which behaviour is deemed to be clinically problematic respectively.

CBCL syndrome scales (Affective, Anxiety, Pervasive Developmental, ADHD and Oppositional Defiant) were also recorded by BTPS staff and the average value of these at intake and exit are presented below (see Table 3) along with the 'main' scores (i.e., Internalising, Externalising, and Total). As can be seen in Table 3, all of the CBCL main and syndrome scores decreased from intake to exit. These decrements were all statistically and clinically significant ($t_{INT}(56)=7.730$, sig = 0.000, Effect size = 0.8; $t_{EXT}(56)=7.125$, sig = 0.000, Effect size = 0.9; $t_{TOT}(56)=8.526$, sig = 0.000; $t_{Affective}(56)=5.999$, sig = 0.000, $t_{Anxiety}(56)=6.811$, sig = 0.000, $t_{PD}(56)=7.708$, sig = 0.000; $t_{ADHD}(56)=3.155$, sig = 0.003, $t_{OD}(56)=5.751$, sig = 0.000), indicating that the BTPS was effective in reducing a wide range of problem behaviours from borderline or clinical levels (indicating significantly maladaptive behaviours) to well within the 'normal' range.

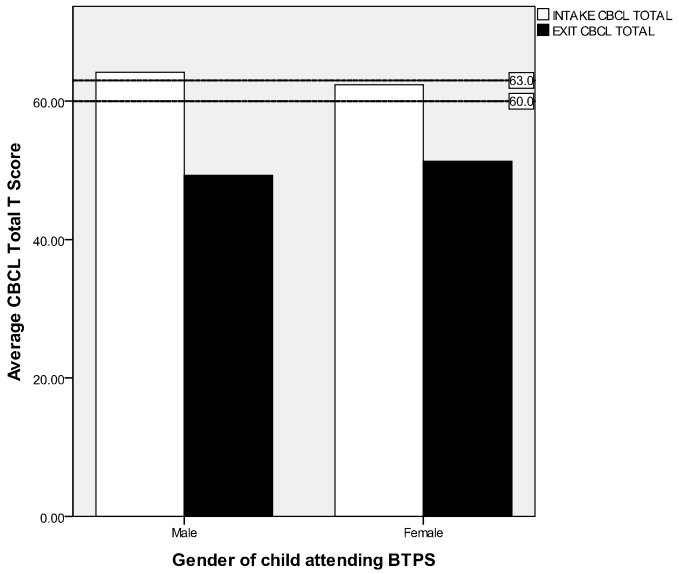

Figure 2. *Average CBCL Total T Scores at Intake and Exit of BTPS differentiated by gender*

Table 3. *CBCL Internalising, Externalising, Total and syndrome T scores at Intake and Exit*

	TOTAL		MALE		FEMALE	
	Intake	Exit	Intake	Exit	Intake	Exit
Internalising	60.7	50.7	62.1	47.3	60.9	52.
Externalising	61.5	50.9	63.7	50.4	60.5	51.
Total	62.7	50.8	64.2	49.3	62.4	51.
CBCL – Affective	61.4	55.6	60.3	55.0	62.2	56.
CBCL – Anxiety	61.2	54.9	62.7	55.3	60.2	54.
CBCL – PD	62.2	55.7	62.7	55.0	61.8	56.
CBCL – ADHD	57.9	53.9	60.3	53.3	56.2	54.
CBCL – OD	61.5	55.5	62.3	56.3	61.0	55.

As the syndrome scales are less robust against gender effects and departures from normality (Achenbach, 1991) due to the small number of items in each scale, only the main CBCL scores were analysed further as a function of major characteristics. As can be seen in Table 4, CBCL Total and Internalising/Externalising T scores all reduced significantly from Intake to Exit regardless of Intake characteristic. Interestingly those children attending the BTPS of Indigenous descent showed the greatest overall improvement in behaviour (as measured by the CBCL). This suggests that the BTPS programme was particularly effective in addressing clinical levels of maladaptive behaviour for children of Indigenous descent.

Child Sexual Behaviour Inventory (CSBI)

As the CSBI is only intended for use with children who have either been, or may have been, sexually abused, Intake and Exit CSBI scores were only available for 29 of the children attending the BTPS (missing values precluded inclusion of all 31 children who had this characteristic was not examined further here. Presented experienced sexual assault). Due to the insufficient persons of Indigenous descent within this sub-sample, in Figure 3 are the average CSBI Total T Scores differentiated by gender, the horizontal line at 65 indicates the level at which clinical intervention is recommended (Friedrich, 1998).

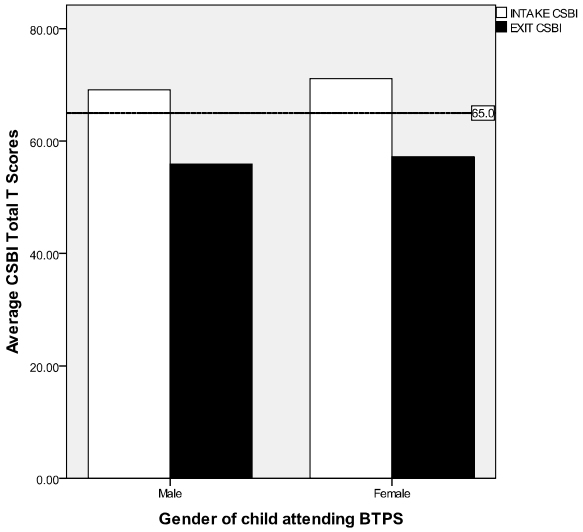

Figure 3. *Average CSBI Total T Scores at Intake and Exit of BTPS differentiated by gender*

As can be seen in Table 5 below, CSBI_DRSB (developmentally related sexual behaviour), CSBI_SASI (sexual abuse specific behaviours) and CSBI_Total scores were all above 65 at Intake but fell to well within the 'normal' range at Exit. These decrements were clinically and statistically significant ($t_{DRSB}(28)=3.029$, sig = 0.005, $t_{SASI}(28)=4.733$, sig = 0.000, $t_{TOTAL}(28)=5.092$, sig = 0.000), with the greatest decrease from Intake to Exit seen in SASI scores for girls (73.5 to 58.9). Effect sizes for these were lower than recorded for the other measures with CSBI_Total being medium (0.6), CSBI_DRSB small (0.4) and CSBI_SASI medium (0.5).

Table 4. *Average CBCL TOT and Externalising/Internalising T scores by major characteristic*

	C&P		**FV**		**SA**		**Indigenous**	
	Yes (n=15)	No (n=42)	Yes (n=49)	No (n=8)	Yes (n=26)	No (n=31)	Yes (n=6)	No (n=51)
CBCL_INT	61/46.6	61.5/51.4	61.6/49.7	59.8/52.9	62.6/50.2	60.3/50.0	63.3/45.0	61.1/50.7
CBCL_EXT	64.9/51.9	60.7/50.4	61.3/50.9	64.6/50.3	62.8/50.7	61.0/50.9	63.5/43.2	61.6/51.7
CBCL_TOT	63.7/48.5	62.9/51.2	63.1/50.3	63.1/51.8	64.1/50.6	62.3/50.4	65.8/44.7	62.8/51.2

* Scores are presented Intake/Exit

Table 5. *CSBI Total and Subscale T scores for Intake and Exit*

	TOTAL		MALE		FEMALE	
	Intake	Exit	Intake	Exit	Intake	Exit
CSBI_DRSB	66.5	57.2	63.4	56.3	67.6	57.2
CSBI_SASI	72.7	58.6	65.3	56.6	73.5	58.9
CSBI Total	71.8	57.6	71.5	56.2	72.1	58.2

Discussion

The BTPS is located within a rural/regional area of Australia that is characterised by relatively high levels of disadvantage and a substantial part of the remit of the BTPS was to provide support to the most 'at risk' children (and their families) within this area. Examination of the intake demographics reveals that the majority of children entering the service had witnessed family violence, nearly half had been sexually abused (with the majority of these being substantiated) and over a quarter were under a Care and Protection order at the time they entered the service. All of the children accessing the BTPS were aged between three and six years at the time of Intake. Research suggests that the earlier the onset of abuse, the more severe the psychosocial impact is likely to be in later life (e.g., Kaplow & Widom, 2007). Thus the children attending the BTPS had prior (early) adverse life experiences which put them at a higher risk for the development of maladaptive behaviours (and further harm). Given that lower educational levels, single parent families and unemployment (as related to lower income levels) are all acknowledged risk factors for increased parental/caregiver stress and lower levels of resiliency (e.g., Campbell-Sills et al., 2009), the fact that the majority of parents/caregivers were unemployed, had relatively low levels of educational attainment and/or were single parents, indicates that the BTPS is providing services, and support, to a segment of the Bundaberg community where there is a higher, a priori, risk for further parenting related stresses and problems.

Efficacy of the BTPS in comparison to published studies

The BTPS had two specific aims: first, to promote resiliency in the children and families attending the service and secondly to address the abuse related symptomatology presenting in the children attending. The first aim was met with evidence of significant improvement in CASPARS scores between intake and exit regardless of intake characteristics. Although the CASPARS tool is not widely used in the published literature, it is commonly used in practice in some American organisations (limiting the ability to directly compare the results found here), the large effect size goes some way to contextualising the findings in that it allows assessment of the treatment effect or standardised difference in scores. Of particular interest is the significant improvement seen in resiliency (as measured by CASPARS) for children who were sexually abused. Many researchers have reported a strong correlation between sexual abuse in childhood and suicidal behaviour in later life (amongst other psychopathology e.g., Nelson et al., 2002) and that resilience may be able to mitigate this relationship (Roy, Carli & Sarchiapone, 2011). Thus the high levels of child and family resilience seen at Exit of the BTPS programme are more than just statistically significant. Importantly however, the programme was not as successful in promoting resiliency in children who have witnessed family violence; in fact analyses showed that the most severe risk to resiliency within the children and families attending the BTPS was experience of family violence. The fact that this risk factor explained more of the variance in outcome scores than gender or experience of other forms of abuse supports the call for further research made by Richards (2011) regarding ways to address the needs of children who have witnessed violence within the family unit.

The BTPS programme was also statistically, and clinically, successful in reducing the psycho-social correlates of the abuse experienced by the children attending the service. For the majority of children, problematic behaviour (sexualised, CSBI, and general, CBCL) reduced from clinical levels to within 'normal' ranges. Sánchez-Meca et al. (2011) report similar effect sizes for reduction in sexualised behaviours as reported here (small to medium) suggesting the BTPS is at least as effective as the international studies examined in their meta-analysis. Various researchers have suggested that sexualised behaviours (including sexual preoccupation) may be particularly resistant to short-term treatment (e.g., Lanktree & Briere, 1995), and less successful for younger children (Sánchez-Meca et al., 2011). However, all of the children for whom a CSBI score was calculable, showed significant (clinical and statistical) improvement in behaviour. Similarly to that reported by Sánchez-Meca et al., girls attending BTPS showed the greatest improvement in sexually-related symptomatology, although this particular finding might be confounded by the higher average number of hours that girls attended the BTPS, i.e., they may have received relatively more intensive therapeutic attention. It must be noted here that the relationship between the child and the abuser was not available thus no determination could be made regarding differential effects of intra- or inter-familial sexual abuse. This is a factor that warrants examination in future studies given that intra-familial abuse may result in more severe consequences (and lower treatment efficacy) given the

increased potential for multiple abuse types (Lalor & McElvaney, 2010).

In contrast, the reduction in generalised behavioural problems (as indicated by CBCL scores) seen following the BTPS exceeds the average effect size reported in the meta-analysis (1.1 vs 0.94, Sánchez-Meca et al., please note that all of the studies included were treatments for sexually abused children), suggesting the BTPS was particularly effective in treating problematic behaviour. Boys, and children of Indigenous descent, showed the greatest improvement in CBCL scores. This latter observation is particularly noteworthy given the high prevalence of abuse recorded for Indigenous children in Australia (Lamont, 2011) and the fact that very little information is available regarding the efficacy of therapeutic interventions with different ethnic and cultural groups (Lalor & McElvaney, 2010). Cohen, Deblinger, Mannarino and de Arellano (2001) mention that few treatment outcome studies examine the effect of ethnicity on treatment efficacy, or importantly, consider accessibility/acceptability of treatment approaches for families of different ethnicities before embarking on treatment design. The BTPS had an *a priori* intention to provide culturally appropriate and sensitive therapy to Indigenous families within the Bundaberg locale. One of the specific ways this was met was by employing an Indigenous Support Worker to work specifically with families identifying as Aboriginal or Torres Strait Islander. The relatively high participation rate of Indigenous families within the BTPS (i.e., 9% of participating families vs 3% in background population) and the significant improvements (both in resilience and psychopathology) seen within these participants is an indicator that the BTPS programme met the needs of these children and their families. This is also significant given that research is divided on whether TF-CBT type therapies are as effective with non-Caucasian children (for a review see Cohen et al., 2001).

A few limitations of the present study are worth consideration. As already noted whether sexual abuse was inter- or intra-familial was not recorded on the assessment sheets available for this evaluation and therefore could not be examined. While this would be of interest in future research, the overall success of the BTPS programme would suggest that there is likely to be a statistical rather than clinical difference. The other limitation is in regard to methodology and treatment approach. That is, in instances where the child attending the BTPS was going through multiple foster care placements, it was difficult to actually work with any parent/caregiver figure in this regard. Two adaptations to the standard TF-CBT model were implemented in the BTPS and noted here. First, while the recommended approach is to utilise audio or video recording when working with parents and children on their interactions, this proved hard to implement as clients often refused permission to record sessions due to concerns about statutory organisations accessing the material. Secondly, due to the ages of the children, session lengths were kept shorter than the one-hour 'standard'.

Although this treatment evaluation has limitations, it is also one of the first to quantify the efficacy of a therapeutic preschool using robust psychometric measures. It may also be the first to examine the differential impact on treatment efficacy of the type of abuse experienced, particularly the effect of witnessing family violence. Sánchez-Meca et al. (2011) specifically recommended the use of such measures as well as the use of independent evaluators (as used here) when determining efficacy. The robust sample size and lengthy data collection period allowed for a rigorous evaluation of the outcome of BTPS (and related stability over time) and the demographic factors that play a part in these (such as Gender and witnessing Family Violence). This enabled the conclusion that the BTPS model resulted in a highly effective treatment/therapy for young children and their families who had been, or were at risk of, harm within the Bundaberg region.

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The Assessment of Problem Sexual Behaviours amongst Children: A Human Rights Centred Approach

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Abstract

The International Convention on the Rights of the Child (1989) declares that all children have inalienable human rights to special care, assistance, and protection. Each child has the right to mental health care services 'as is necessary for their well-being' and opportunities for rehabilitation at 'the highest attainable standard'. A human rights centred approach to responding to children who display problem sexual behaviours calls upon government, government agencies and professionals to provide accurate assessment and efficacious, evidence-based treatment in a manner that builds the child's sense of dignity and worth. A human rights centred approach to assessment calls upon all professionals to recognise, reflect upon, and respond to children's sexual behaviours in a manner that prioritises the dignity of the child by identifying who should assess and what should be considered in the assessment of children's sexual behaviour.

Introduction

The International Convention on the Rights of the Child (1989) declares that children have special rights due to their extreme vulnerability in comparison to the power of adults in positions of authority. This paper explores two human rights that apply to children who come to the attention of authorities and professionals due to their sexual behaviours. The first is the right to assessment by professionals ably qualified to undertake the task. It is suggested that the highest degree of scholarship and professional experience is a necessary precondition for undertaking a psychosexual assessment of a child. Given the complexity and uniqueness of each child, psychosexual assessments of children's sexual behaviour must recognise the differences in children's mental states and personal needs, reflect upon the whole person of the child (including the contexts within which they live), and identify responses that will not only reduce the risk of harm to the child and others but consider their needs as a whole person. The second right is that all responses recommended following a comprehensive assessment promote the child's sense of dignity and worth, reinforcing the child's respect for the human rights and the fundamental freedoms of others, and promotes the child's integration in society.

Human Rights of Children

Article 25.2 of the *Universal Declaration of Human Rights* (1948) proclaims that children are entitled to special care, assistance, and protection. In keeping with this, the United Nations, through the *International Convention on the Rights of the Child (1989)* announced its vision for children asserting that, amongst other rights, each child has the right to protection from abuse.

Article 3 of the *International Convention* calls upon those in positions of authority – such as government officials and professionals who have the capacity to powerfully impact on the lives of children and their families – to 'ensure the child such protection and care as is necessary for his or her well-being'. Article 24 asserts the right of children to 'the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health' and that no child should be 'deprived of his or her right of access to such health care services'. Article 39 asserts that those in authority must 'take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation, or abuse' and that 'such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child'. Article 40 proclaims that every child who is alleged or accused of having infringed or committed a crime, must 'be treated in a manner consistent with the promotion of

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the child's sense of dignity and worth, which reinforces the child's respect for the human rights and fundamental freedoms of others and which takes into account the child's age and the desirability of promoting the child's reintegration and the child's assuming a constructive role in society.'

The right to special care, assistance, and protection

A human rights approach to responding to children's sexual behaviour – as articulated by Butcher and Webster (2006) – calls upon government, government agencies, and professionals not only to ensure the protection of each child but to ensure that they are provided assistance in overcoming any physical or psychological condition that impairs their well-being and/or recovery from trauma.

Grant and Ludeberg (2009) provide an extensive list of factors found to negatively impact on the sexual development of children. These include "sexual abuse, physical abuse, neglect, medical/health problems, mental health issues, behavioural disorders, learning disabilities, social deficits, high levels of family stress, lack of age-appropriate sexual information, disrupted parent-child relationships, exposure to highly sexualised material/information, rigid or overly restrictive family views regarding sexuality, poor family boundaries, overly punitive/permissive parenting, unstructured home environments, parents or other key relationship figures modelling inappropriate sexualised behaviours, etc." (Grant & Lundeberg, 2009, pt.1.p.5)

While research is limited in the area of problem sexual behaviour, it has consistently been found that such behaviour emerges from a combination of multi-determining variables rather than from any single causal factor. The Association for the Treatment of Sexual Abusers (ATSA) identified a range of factors contributing to problem sexual behaviours in their literature review published in the *Report on the Task Force on Children with Sexual Behaviour Problems* (2006). These included familial, social, economic and developmental factors identified by Friedrich (2001, 2003); prior sexual abuse experiences (Friedrich, 1993; Friedrich, Trane & Gully, 2005; Johnson, 1988,1989; Friedrich, 1988; Bonner, Walker, & Berliner, 1999; Silovsky & Niec, 2002); and physical abuse, neglect, substandard parenting practices, exposure to sexually explicit media, living in a highly sexualized environment, and exposure to family violence (Friedrich, Davies, Feher, & Wright, 2003). Langstrom, Grann & Lichtenstein (2002) identified evidence that heredity also may be a contributing factor. Bonner, Walker, Berliner, Bard and Silovsky (2005) found that the more intense a child's problem sexual behaviour, the more likely they are to have co-morbid mental health, social and family problems.

Given the aetiological link between children's experience of abuse in some form (physical, emotional, sexual abuse, exposure to domestic violence, and neglect) and problem sexual behaviour, nation states who have ratified the *International Convention* are obliged to provide programs of rehabilitation, based on a thorough assessment undertaken at 'the highest attainable standard'. The following scenario (a compilation of cases) makes the point.

Troy is an 8-year-old boy who has been in the care of the State for most of his life and will continue to be so until the age of 18 years. He was removed from the care of his birth parents due to extreme physical abuse. For the last 2 years, Troy has been exhibiting a range of sexual behaviours that caused physical and psychological harm to several children who were considerably younger than him. His foster carers pleaded with the government department ultimately responsible for meeting his needs to fund treatment, but to no avail. In their desperation, they took out a loan to pay for private treatment with a specialist in the field. Troy responded favourably to treatment over the following 12 months. Reports about his sexual behaviours ceased and improvements were recognised in his performance at school and in his relationships with peers, however his aggressive behaviour toward his foster siblings and parents continued. When the foster placement broke down, the government department responsible for Troy's care refused to fund the continuation of treatment. No reason was given for this decision, but it was public knowledge that the department had recently been the target of major budget cuts. Troy was not provided with any alternative treatment despite his hostile behaviour escalating after the placement breakdown. The losses of relationships with members of his foster family, school community and treating clinician were considered to significantly raise the risk of him sexually abusing again… only this time, being above the age of criminal responsibility, he would most likely be charged, adjudicated and enter the juvenile justice system.

Children such as Troy are amongst the most vulnerable in society. The *NSW Standards for Statutory Out-of-Home Care* (The Children's Guardian, 2010) acknowledge that "children and young people with unmet mental health, social or emotional needs are particularly vulnerable to placement breakdown" and that they "often have poor health status and a fragmented treatment history". Emphasis is therefore given to the role of the caseworker being "crucial in facilitating and co-coordinating effective health assessments and planning" (2010, p.9-10). Children in care often do not have family members who are able or available to advocate for them in terms of their rights

when professionals and agencies do not meet the minimum standards of care and ethical practice that is their right under the *International Convention*.

Under the *International Convention*, any response to the sexual behaviour of a child (such as assessment, case-planning or treatment) must be undertaken in such a way that recognises the child's uniqueness and value as a human person. Not only should all attempts be made to protect children and their families from harm due to an intervention, but the human rights goal of any response directs that the child emerge from the experience with a sense of dignity and worth, resulting in them not only feeling a part of society but ready to take a constructive role within it. When a rights centred approach is not adopted by those 'investigating' children's sexual behaviour, harm often results – as occurred in the following example.

Several years after it was established that 12 year old Sebastian[1] had been wrongly determined to have been "a sexual abuser", he reflected on his experiences of police and the actions of caseworkers;

> *They put a label on you. They pointed the finger at me and gave me a filthy look. They wanted me to sign papers… I realised: "You can be charged over this"… I was at the lowest of the lowest. I felt like that and stepped into that role. I didn't have to… I realised that I wasn't supposed to be at the Children's Court. I can't remember what was said at Court for the AVO. People were shuffling… The tables turned… They interpret to suit their agenda. It was not what I said. It was a different context… I was so thankful that my mother stood up for me… For local and federal MPs it is too hard a case. It is up to us. (Sebastian. Quote taken from qualitative research for the purposes of Butcher & Webster, 2006).*

Butcher and Webster (2006) argue that the case of Sebastian reflects multiple failures on the part of government to meet their obligations to children and families under the *International Convention*. As a result, the systemic response harmed Sebastian and his family. An essentially clinical decision was made by police and caseworkers who lacked the necessary expertise to distinguish whether the children's sexual behaviour was normative or problematic (in breach of Articles 24, 39 and 40 of the *International Convention*). Police and caseworkers 'established' that Sebastian had sexually abused. This decision was made without Sebastian being interviewed. This was a breach of Sebastian's right to have his views taken into account (Article 12.1).Sebastian was not charged with a sexual offence so he was therefore not adjudicated. His right to an independent and fair hearing (Articles 9, 10 and 12.2) was not met. He was therefore not afforded the guarantees of due process prescribed under the *International Convention* (in breach of Article 40.2). Sebastian's parents' views were not taken into account by those who made the decisions (in breach of Article 5) nor were the parents able to exercise their right to argue their position to an independent authority (in breach of their rights under Articles 9.2 and 10). There was no structure for periodic review of the decisions made (in breach of Article 25).

Butcher and Webster (2006) argue that a rights centred approach to recognising, reflecting upon, and responding to individual children who engage in problem sexual behaviour reduces the risk of systemic harm being done to children and their families. It is suggested that the multiple human rights violations suffered by Sebastian may have been avoided if a thorough evidence-based psychosexual assessment had been completed by an expert prior to any casework decisions being made, and if human rights principles guided the response plan.

The right to professional practice at 'the highest attainable standard'

A human rights approach to responding to children's sexual behaviour not only calls upon government and government agencies to meet 'the highest attainable standard' as specified by the *International Convention*. Further, professionals and paraprofessionals are ethically and often legally bound by values that promote the child's sense of dignity and worth. For example, the Australian Psychological Society lists 'respect for the rights and dignity of people and peoples' as its first general principle:

> 'Psychologists regard people as intrinsically valuable and respect their rights,. Psychologists engage in conduct which promotes equity and the protection of people's human rights, legal rights, and moral rights. They respect the dignity of all people and peoples.' (APS, 2007, p.11)

Under this code, psychologists are required to:

> 'communicate respect for other people through their actions and language… not behave in a manner that, having regard to the context, may reasonably be perceived as coercive or demeaning… respect the legal rights and moral rights of others and not denigrate the character of people by engaging in conduct that demeans them as persons, or defames, or harasses them.' (APS, 2007, p.12)

Webster (2006) proposed a process model for assessing the sexual behaviours of children that

[1] This case was initially described by Webster and Coorey (2004).

considers human rights centred interventions to comprise three essential stages: Recognise, Reflect, and Respond. Children's rights to protective and rehabilitative responses are facilitated if their needs and vulnerabilities are recognised by adults, the entirety of their personhood (including their personality) and context (environment) is considered, and responses are generated that promote the child's sense of their dignity and worth as well as the dignity and worth of others. This model is equally relevant to clinicians and non-clinicians, professionals and paraprofessionals, experts and generalists in the field. Due attention to each of the stages is necessary to strengthen and maximise the quality of an intervention and minimise the risk of harm to children and families who come to the attention of authorities and clinicians.

The 3 R's model of intervention is an adaptation of the "see, judge, act" model of social change proposed by Joseph Cardijn. Cardijn (1964) asserted the need to see injustice where it exists, critically evaluate and judge the circumstances, and act effectively on the conclusions drawn. In the model's adapted form, as presented here, it is important for each professional and paraprofessional who works with children to have the capacity to recognise, reflect upon and effectively respond to children who engage in problem sexual behaviour to the extent their professional role requires.

A human rights approach to responding to children's sexual behaviour argues the case for informed practice based on scholarship to the degree appropriate to the professional's role. The greater the impact decisions made by a professional or paraprofessional have on the life of a child, the greater the need for scholarship in the field. Non-clinical professionals (such as child protection caseworkers, teachers, and police, etc.) and paraprofessionals (such as teachers assistants, sports coaches, and youth workers who do not have a relevant clinical degree) play an important role due to their enhanced capacity to identify sexual problems that *may* exist for a child – their capacity being 'enhanced' by professional training in child protection as related to their workplace roles, responsibilities, and authorisations.

The rights centred approach, argued here, emphasises that the primary role of non-clinical personnel within the child protection domain is to question whether observed or reported sexual behaviours of a child are normative or 'of concern' and to refer on to clinicians with expertise when a child's behaviour is discerned as 'concerning'. At a minimum, it is argued that this requires knowledge about the variation of children's autoerotic and interpersonal sexual behaviours and an awareness of general principles that distinguish children's sexual behaviours as normative or concerning in some way and to some extent.

While the 'highest standard' requires all professionals and paraprofessionals to have a foundational knowledge of the literature that is sufficient for the process of reflecting upon whether a child has engaged in *problem sexual behaviour,* clinicians who take on the role of assessing the mental state and sexual behaviours of children require particular expertise. Hence, a high degree of scholarship in these areas is a pre-requisite for having sufficient capacity to determine whether a child has a *sexual behaviour problem* and what program of rehabilitation, if any, is most likely to be helpful and respectful of the entirety of their rights.

Once a child has attracted concern due to their sexual behaviour, it is essential they be introduced to personnel with sufficient expertise to make highly complex clinical judgements about whether an individual child does have psycho-sexual issues that require intervention – and if so, the most appropriate intervention. Professionals are bound by codes of ethics to practise within the limits of their competence. In the case of assessing a child's psycho-sexual status and sexual behaviours, not only are professionals responsible for ensuring that they are competent to deliver the services they provide, they must ensure that their services are of benefit and do no harm to the child. The APS Code of Ethics, for example, asserts that psychologists should work 'within the limits of their education, training, supervised experience and appropriate professional experience' (APS, 2007, p.18).

The ATSA Taskforce concluded that clinical assessments should be conducted by 'degreed, mental health professionals and who are licensed appropriate to their discipline and according to local laws' (2006, p.6) The Task Force identified six areas of expertise as prerequisites that qualify a professional to undertake the psychosexual assessment of a child. Expertise is required in:

1. Child development theory and research– including typical sexual development and behaviour;
2. Differential diagnosis of childhood mental health and behavioural problems;
3. Diagnosing common problems seen among children with sexual behaviour problems – such as non-sexual disruptive behaviour problems, learning disorders and developmental issues, Attention Deficit Hyperactivity Disorder, child maltreatment, child sexual abuse, trauma and posttraumatic stress related problems, and conditions that may affect self-control, such as hyperactivity disorder and childhood bipolar disorder;
4. Understanding environmental, family, parenting and social factors related to child behaviour, including the factors related to the development of sexual and nonsexual behaviour problems;
5. Familiarity with the current research literature on empirically supported interventions and treatment

approaches for childhood behaviour and mental health problems; and

6. Cultural variations in norms, attitudes and beliefs about childrearing and childhood sexual behaviours.

Professional interventions aimed at children carry the potential to either facilitate development or to cause harm. The assessment of a child's sexual behaviours by a person who has insufficient expertise (and therefore fails to meet the 'highest attainable standard') not only compromises the opportunity to ensure that the appropriate response is provided to the child but violates their human rights. Children who are wrongly assessed as not having problem sexual behaviour when they do (a false negative) are at greater risk of harming other children or themselves as they will not receive the ongoing professional assistance they need to be properly rehabilitated. Children who are wrongly assessed as having problem sexual behaviour when they do not (a false positive) are at greater risk of being deprived of other human rights – such as their right under Article 9 of the *International Convention* to live with their own family (Webster & Coorey, 2004).

The 3 R's for clinically assessing problem sexual behaviour amongst children calls upon expert clinicians to (1) be adequately equipped to be able to *recognise* the variation of normative and problem sexual behaviour through professional training and scholarship in the field; (2) enter into a process of professional *reflect*ion that facilitates sound clinical judgements based on all information available; and (3) establish a treatment plan that *respond*s to the assessed psycho-social needs and human rights of all children involved and their families.

When to refer: Scholarship for professionals and paraprofessionals

Children engage in a range of sexual behaviours from infancy with friends and, at times, siblings and cousins. There are various factors that facilitate children giving expression to their 'natural' sexual interest. Children have frequent contact with each other and, given the level of trust within the home or the home of a friend or relative, such contact can go unsupervised for considerable periods of time (Johnson, 2003).

In an environment of free access, trust and emotional closeness, it is relatively easy to take opportunities to enjoy the experience of sexual pleasure and learning. However, those same factors that provide opportunities for psycho-sexual development also lend themselves to confusion and distress, particularly if the experience becomes too intense or lacking in mutuality.

Theorists and researchers generally agree that most children engage in healthy sexual behaviour (Friedrich et al., 2001; Grant & Lundeberg, 2009). Some, who have usually been traumatised, engage in behaviours that are more complex and can be self-destructive and, for some children, harmful to others. Johnson (1991) was amongst the first to distinguish sub-types of problem sexual behaviour of children. Johnson's emphasis focusses on (1) the age-appropriateness of the nature and frequency of sexual activity by a child or between children and (2) the child's responsiveness to correction by adults. Four clusters or groups of children under 13 years of age were identified on the continuum of sexual behaviours:

1. Children engaging in natural and healthy childhood sexual play;
2. Sexually-reactive behaviours – where the child's focus is out of balance compared with their peers;
3. Extensive mutual sexual behaviours – where the child may engage in a full spectrum of adult behaviours, generally with age-mates; and
4. Molestation Behaviour – children who harm others through their sexual behaviours.

Gil and Johnson (1993) established the principle that children's sexual behaviours fall on a continuum from mutually agreed experimentation to sexual behaviour that is 'of concern' or problematic when it causes harm. In his research into the sexuality of non-abused children, William Friedrich concluded that "sexual behaviour in children is typically non-pathologic, follows a developmental course, and can be quite varied" (Friedrich, Davies, Feher, & Wright, 2003, p.119). Healthy sexual behaviours are considered formative and facilitative of cognitive, emotional, and social development – particularly if they take place in appropriate settings and with appropriate partners (Grant & Lundeberg, 2009). Sexual behaviours cease to be normative and healthy when there are potentially harmful effects for the child themselves or others involved as participants in or witnesses to the sexual activity (Johnson, 1991).

Sexual behaviour is clearly problematic when it causes harm to others. Ryan's (1997) tripartite model identifies the factors of equality, consent and coercion as central to defining a child's sexual behaviours as 'abusive'. Ryan avoided classifying the child but instead created two separate lists of sexual behaviours of children 12 and under, and over 12 years, categorising behaviours according to four levels of severity – green flag, yellow flag, red flag and abusive behaviours. Pratt and Miller (2010) gave clearer descriptive titles to the first three of these categories: 'age appropriate sexual behaviours', 'concerning sexual behaviours' and 'very concerning sexual behaviours'. More recently, Brennan and Graham (2012 - book reviewed in this edition) use traffic lights as a metaphor to differentiate the sexual behaviours of children into those that are normal (green light), outside normal

behaviour (orange light) and those that are problematic or harmful (red light sexual behaviour). The higher levels of severity imply the greater need for professional intervention – including reporting behaviours to the authorities, subsequent expert assessment, and evidence-based rehabilitative responses.

Such concepts and lists can be very helpful resources for professionals and paraprofessionals working with children particularly when reflecting upon whether a child's behaviour requires some form of action. Such lists purposely reduce the complexity of children's sexual behaviour to simple notions that are accessible and usable by most people in the community. It is important to emphasise, however, that the misuse of such lists to the extent of over-reliance or exclusive reliance upon them to discern the psychosexual mental state of a child raises the risk of the child's rights being compromised along with their future psychological well-being.

What to assess: Scholarship for experts

One of the reasons why the assessment of children's sexual behaviours needs to be undertaken by experts is because research on the topic is limited and the range of psychometric instruments is small. As indicated by the extensive list of prerequisite knowledge and skill for experts identified by the ATSA Taskforce (above), an expert clinician has to draw from the entirety of their professional training and supervised practice in order to complete the task of assessing a child's psycho-sexual status to 'the highest attainable standard'.

Four essential questions need to be asked in a rights centred approach to the assessment of children whose sexual behaviour and psychosexual mental health is under consideration:

1. Are the reported behaviours normal and healthy or problematic?
2. If the sexual behaviours are problematic, what type of problem is presented?
3. What place do the sexual behaviours have in the child's overall mental state?
4. What psychosocial responses are available for remediation?

Are the reported behaviours normal and healthy or problematic?

Children have the right to have the uniqueness and complexity of their personalities assessed particularly when the results of an assessment may have a profound effect on their lives. In undertaking an assessment, experts are ethically bound to respect the right of children to be fully understood by those who are assessing them rather than being subjected to an innately devaluing process that depersonalises the child and compromises their human dignity by an exclusive focus on their behaviour.

This paper argues that the process of assessing the sexual behaviours of and between children first needs to consider their sexual activities against age-related norms. If an individual child's behaviour falls outside the norms, a clinical decision then needs to be made about the extent to which the behaviours are harmful. Harm may relate to the child him or herself, and may be intra-psychic and/or social. Harm to other children is recognisable if a child's actions constitute sexual abuse.

While acknowledging their limitations, reference lists such as those presented by Araji (1997), Johnson (1998), or Ryan (2000) and empirically derived psychometric instruments such as the Child Sexual Behaviour Inventory developed by Friedrich (1997) assist in comparing an individual child's behaviour against age norms. The ATSA Taskforce (2006) conducted a literature review to assist experts in determining whether a child's sexual behaviour is appropriate and healthy or not and whether it is harmful. Their findings were based largely on the research of Araji (1997), Hall, Mathews, & Pearce (1998), and Johnson, (2004).

The Taskforce found that the assessment of 'appropriateness' should take into account of:

1. whether the child's sexual behaviour is common or rare in terms of their developmental stage and culture;
2. the frequency of the behaviours;
3. the extent to which sex and sexual behaviour has become a preoccupation for the child;
4. whether the child responds to normal correction from adults or continues to occur unabated after normal corrective efforts;
5. whether the behaviour involves potential for harm;
6. the age/developmental differences of the children involved;
7. any use of force, intimidation, or coercion;
8. the presence of any emotional distress in the child or children involved;
9. whether the behaviour appears to be interfering with the child or children's social development; and
10. whether the behaviour causes physical injury.

Pithers, Gray, Cunningham, and Lane (1993) identified five criteria to determine if a behaviour set is normative, problematic or abusive. These comprised

1. the extent to which the type of sexual activity is consistent with the child's developmental level;
2. the extent to which the children have equal power;
3. the extent to which force or intimidation were used;
4. the extent to which secrecy was involved; and
5. whether the behaviour has an impulsive or obsessive quality.

These findings conceptualise problem sexual behaviour in a manner that shifts the focus from the type and frequency of sexual behaviour to the nature of the problem for a child or between children. All of the identified criteria call for professional reflection upon quantitative and qualitative data concurrently, in recognition that the sexual behaviour of children is a complex phenomenon and professional judgements need to be made in reference to the whole person of the child.

If the sexual behaviours are problematic, what type of problem is presented?

Staiger and Kambouropoulous (2005) identified three circumstances in which the sexual behaviour of a child can be problematic: (1) where the child is psychologically harmed by the behaviour; (2) where the child's behaviour places them outside societal norms; and (3) where the behaviour is abusive. According to them, sexual behaviour is problematic when it causes others to feel uncomfortable, occurs at the wrong time or place, and/or it conflicts with family or community values. Likewise, it is problematic when it puts the child at risk of abuse from others, interferes with his or her psychological development and relationships, violates rules, is self-abusive and/or is defined by the child as a problem.

While there may not be strong evidence for distinct empirical clusters, from a human rights perspective, it is of great importance that some differentiation be made between the various types of healthy behaviours and problem sexual behaviours. In particular, from a children's right's perspective, it is argued that assessments of children's problem sexual behaviours should specify what kind of problem has been identified. A lack of clarity in 'what the problem actually is' clouds the identification of what responses need to be implemented and can lead to a 'one size fits all' response.

A failure to recognise, reflect upon and respond to the specific needs of the child fails to recognise their dignity and worth by ignoring who they are as a unique person. Further, the formulaic imposition of a prescribed set of interventions is likely to further compromise the child's mental health, social well-being and human rights. Specific descriptions of what problem, if any, a child has not only guide clinicians toward the appropriate recommendations for casework responses (including treatment), but also offer some clarity to authorities about whether action is warranted to protect other children.

Taking into account the limited but existing literature, it is proposed that the sexual behaviour of and between children be categorised as Healthy (Type 1) or Problem Sexual Behaviour (Type 2). In total, the sexual behaviours of children may be conceptualised as fitting into any of five sub-types, comprising:

TYPE 1: HEALTHY

Type 1A: Normative	The sexual behaviours are age-appropriate and facilitate psycho-sexual development.
Type 1B: Exaggerated	The sexual behaviour is outside age-related norms but does not cause harm to any child and is done in such a way that does not unduly expose the child to harsh reactions of others (e.g. unusually frequent auto-erotic activity or interpersonal sexual experimentation).

TYPE 2: PROBLEM SEXUAL BEHAVIOUR

Type 2A: Sexualised	The child is psychologically harmed by their own behaviour as it is indicative of psychopathology (e.g. a re-enactment of prior trauma).
Type 2B: Affronting	The child may be at risk of social sanctions as their behaviour places them outside societal norms (e.g. engaging in sexual behaviours in the school playground).
Type 2C: Harmful	The behaviour poses a risk of harm to others where issues of inequality, absence of consent, and/or coercion are present.

All problem sexual behaviour is concerning and requires professional intervention as is the right of each child.

What place do the sexual behaviours have in the child's overall mental state?

A rights centred approach requires that the child be assessed in a manner that recognises their dignity and wholeness as a person. By contrast, assessments that focus exclusively on particular instances of sexual behaviour degrade the personhood of the child. The assessment of problem sexual behaviour is now recognised as a multifaceted endeavour. As with the literature on child maltreatment in general (Scannapieco & Connell-Carrick, 2005) and as outlined above, the assessment of problem sexual behaviour requires a comprehensive approach that takes into account the developmental stage of the child as well as prevailing ecological risk factors at varying systemic levels.

Developmental and ecological perspectives are important theoretical frameworks in the assessment of a child's presenting sexual behaviour (O'Brien, 2010). Hence, a comprehensive understanding of a child's

sexual behaviour must consider how the family (and other) systems increase or decrease the likelihood of the child engaging in concerning behaviour (Minuchin, 1985). Failure to consider systemic factors risks the child being labelled and singularly blamed for behaviours that are socially constructed (O'Brien, 2008). For a comprehensive schedule of questions to be considered when assessing the sexual behaviours of post-pubertal children, see Pratt and Miller (2010).

The right to assessments that promote the child's sense of dignity and worth

A rights centred approach is consistent with codes of ethics that require professionals to conduct assessments in a manner that communicates to the child their value as individuals, who have a range of rights as well as the entitlement to be treated with dignity. There are two aspects in which psychosexual assessments should promote a child's sense of dignity and worth: the quality of interaction between the child and the professional; and (2) the recommendations drawn from the assessment.

The rights centred approach to assessment, articulated here, prioritises the need for professionals to communicate to each child that they are valued. This is achieved by focussing on the child's uniqueness and through the quality of interpersonal interaction between the professional and the child. It is argued here that both human rights and therapeutic action are anchored in the consistent empathically based "spirit of enquiry" (Lichtenberg, Lachmann, & Fossage, 2002) that leads to 'the cocreation of a profound experience of being seen, understood, and known by a deeply caring person' (Fosshage, 2006, p.329).

The clinician's 'optimal responsiveness' (Bacal, 1998) to the child's implicit and explicit communications assures the child that they are being recognised and valued at the deepest levels of their personhood – at a time that they are perhaps most vulnerable. The clinician's engagement with the child through empathic attunement, confrontation, support, self-disclosure, validation and invalidation asserts that the child is worthy of the clinician's attention and care. A rights centred approach holds that children experience a sense of their dignity and worth during an assessment when clinicians approach them with sensitivity and affirmation. Even in instances where children are resistant to the overtures of clinicians to connect with their experience, the respectful way children are spoken to, the way their views are taken into account, the manner in which they are informed about the processes they are experiencing, as well as the explanations and responses to any questions the child might have, communicate the presumption of the child's worth in the eyes of the clinician.

Great care needs to be taken in the selection of psychometric instruments, not only in terms of their relevance for the child's developmental level but, more importantly, that the instruments selected do not cause distress to the child (ATSA, 2006). For example, phallometry is not appropriate for use with children and adolescents due to the invasive nature of the procedure, amongst other reasons.

Children are often not voluntary participants in the assessment process. The need for assessment is typically recognised by an adult rather than by the child. There is a strong potential for the assessment to be experienced by the child as a coercive and potentially humiliating. Therefore, the onus rests with all professionals who have direct contact with children to reinforce each child's sense of worth. The rights centred approach acknowledged that some degree of intrusiveness is inevitable in a psychosexual assessment. As such, an even greater onus rests on the expert to ensure that each child's rights are respected.

The second aspect of an assessment aimed at promoting the child's sense of dignity and worth relates to the recommendations drawn from assessment findings. Recommendations for responses must directly consider and include strategies that support the child's sense of dignity and worth. The human rights centred approach calls on experts to reflect upon the treatment needs of their child clients through the filter of human rights principles. As such, the expert should recommend specific responses that go beyond the aim of eliminating problem sexual behaviour. The expert's recommendations should:

1. promote the child's awareness of the rights of vulnerable others;
2. ensure that, by the end of their program of rehabilitation, the child feels they have an equal place in society; and
3. facilitate the child's integration in the community in a manner that allows them to fully participate in all aspects of life that is normal for children according to the cultural standards of their community.

Case planning in relation to contact with other vulnerable children is of particular importance when a child has engaged in harmful behaviour (Pratt & Miller, 2010). Care needs to be taken in relation to other children with whom the child has contact – such as siblings, other students at school or day-care, sporting activities, etc. On some occasions, it may be necessary to impose sanctions on the child to reduce opportunities to engage in behaviours that cause harm. However, in respect of the child's rights, this must be accomplished by the least intrusive means while guaranteeing community safety. Safety strategies should be closely monitored with a view to restoring the normal degree of

contact between the child and their community where possible and as soon as it is safe enough to do so.

The purpose of a psychosexual assessment is to clarify the individual qualities of a child's personality and the patterns of their behaviour so that decisions about future responses are tailored to the specific needs of the child. Given the limitation of research in the area of children's problem sexual behaviours, a treatment of choice has not emerged. This places a greater burden on the expert to consider the various treatment approaches that are available to children. Recommendations need to be made in terms of the child's identified treatment needs. Recommendations about future treatment should not only consider the most appropriate treatment approach or intervention, but also the most appropriate person(s) to take on the role of treating the child.

Specificity Theory (Bacal, 2011) argues that therapeutic progress is made within the relational context of the clinician and the child client – comprised by the operation of a unique, complex, and reciprocal relational system. 'Specificity Theory is premised upon the recognition that each person is unique; each relationship is unique; and, therefore, every therapeutic relationship is unique' (Munschauer, 2006, p.465). Specificity theory 'calls attention to the importance of improving the therapeutic fit between the (child's) particular therapeutic needs and the (clinician's) capacity to respond to them' (Bacal, 2007, p.125). As highlighted above, children who engage in problem sexual behaviour typically need to address a range of complex psychological issues. A child's right to treatment 'at the highest attainable standard' is respected if they are matched to clinicians that fit their personality and identified needs.

Assessment reports relating to children's psychosexual status should make their time-limited quality explicit. The ATSA Task Force noted that the behaviour and status of children can quickly change over time as (1) children are in a process of development and maturation, and (2) their circumstances and the social environment can change quickly. Consequently, the validity of any clinical assessment must be considered time-limited. "Good child assessment reports often include explicit statements to guard against inappropriate use of the report long after its validity has expired'. (ATSA, 2006, p.12)

Conclusion

This paper prioritises children's rights to special care, assistance, and protection. Children whose sexual behaviour draws the attention of authorities and professionals are entitled to care and rehabilitation as is necessary for their well-being. Any response to a child's sexual behaviours should be undertaken at 'the highest attainable standard'.

The process model of 'recognising, reflecting upon and responding to' children's problem sexual behaviours provides a framework to guide professionals and paraprofessionals toward meeting the rights of children who display problem sexual behaviours. Each child has the right to be recognised: to be seen, understood, and known as a unique person and to be responded to in a manner that builds the child's sense of dignity and worth.

The rights of children are respected when professionals and paraprofessionals intervene to the level their training prescribes. The highest standard of scholarship and supervised experience is a pre-requisite for professionals assessing children's sexual behaviour. National counsellor accreditation systems offer some guarantee of professional standards in the assessment and treatment of children with problem sexual behaviour. However, for such systems to have their greatest impact, a culture needs to be established (perhaps reinforced by policies) that expose the services of non-accredited professionals as a risk to the rights of children.

Future research should explore the following areas:

1. *Scholarship for professionals and paraprofessionals:* Awareness of scholarship in children's sexual behaviour is essential to non-expert professionals and paraprofessionals to enable the recognition of, reflection about, and responses to individual children.

- •Research into the knowledge and attitudes of police, caseworkers, teachers, etc. would guide government and government agencies on professional development needs and build the capacity of professionals to respond in a rights centred manner.
- •Research is required into the extent to which awareness about the complexity of children's sexual behaviours informs the interventions of non-experts. Data on frequency with which authorities call upon the expertise of clinicians when making important decisions about children's lives would assist in identifying gaps in each nation state's attempts to ensure the rights of children.

2. *Scholarship for experts:* The psychosexual assessment of children should be undertaken by experts.

- •Research into the level of knowledge and skill held by clinicians who currently identify as experts would assist in clarifying whether children's right to 'the highest attainable standard' of assessment is being met.
- •It is important that those working in the field share their insights and professional experience of their work with children who engage in problem sexual behaviour by publishing case studies and other research. It is only through scholarly debate that the knowledge base in relation to children's sexual behaviours will grow.

3. Assessments promoting the child's sense of dignity and worth:

•A regular review of assessment procedures is required by all government agencies to ascertain degree of their compliance to children's human rights. The findings of such reviews should be published.

•Research into the theoretical bases of available treatment responses would identify the extent to which they promote the child's sense of dignity and worth, reinforcing the child's respect for the human rights and the fundamental freedoms of others, and promote the child's reintegration in society.

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Who Thinks What about Child Protection: Community Perceptions and Awareness of Child Protection Strategies and their Effectiveness for Reducing Sexual Reoffending

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Abstract

The Child Protection Register of New South Wales (hereafter referred to as the "Register" or "Registers" for the general case) reflects an Australian version of a type of initiative employed internationally in the community management of sex offenders with a view to child protection. Such Registers have come out of a hard line push for "law and order" that has seen sex offenders demonised and the risk they pose to the community inflated, especially by the media. Research, however, has found no tangible effect of Registers in reducing sexual recidivism. Public opinion suggests that Registers are "important" and the current research extends the literature to examine how people living in Sydney, Australia, understand the Register and how this impacts on child protection in the community. The results suggested that participants were ill-informed about the Register, over-estimated risk for reoffending, and that those with children living with them were more likely to desire punitive strategies in managing sex offenders. The implications of this were explored in light of the extant literature and with a view to implications for child protection.

Introduction

In 1994, laws were introduced in several American states in response to high profile cases involving the sexual assault, kidnapping and/or murder of children[1]. The offences which initiated the creation of these laws prompted public outrage, with many people arguing that the public would have been better equipped to protect their children had they been informed that a convicted offender was living nearby (Gaines, 2006). Laws, such as Megan's Law, provided the legal authority for the creation of Registers throughout the United States of America for sexual offenders who had committed offences against children and for the data on these Registers to be made public so that the community would be informed (either passively, via information accessed through a website or actively, with the information being provided to residents) if an offender was moving into a particular area.

Despite public outrage at the perceived risk that sex offenders pose to children (Mills & Kroner, 2006), the research is unequivocal in establishing that compared to most other types of violent offenders, sex offenders have low base rates of reoffending; with around 10-25% new convictions for sex offences over 15 years (e.g., Bonnar-Kidd, 2010; Levenson, Brannon, Fortney, & Baker, 2007). Moreover, given that the vast majority of sex offenders are first time offenders who are known to their victims (e.g., Sandler, Freeman & Socia, 2008; Vandiver & Kercher, 2004), it seems unlikely that knowledge regarding the presence of registered sex offenders in the neighbourhood would offer protection against "known" sex offenders.

Child sexual abuse is an issue at the forefront of the platforms of many political parties, with imprisonment of offenders being a significant issue for political parties to support in a bid to appear to take a serious line on protection of society from criminals (Hayes et al., 2009). In the present climate, child sex offenders have become the personification of 'evil intent'; predators stalking and hunting their prey and damaging children (Comartin, Kernsmith & Kernsmith, 2009; Vess, 2009). Despite no evidence to suggest that child sexual abuse has increased in frequency from the mid-1980s (Casey & Nurius, 2006; Wyatt et al, 1999), the media interest in child abduction, sexual assault and/or murder perpetuates a fear that all children are at risk

[1] Megan's Law was enacted after Megan Kanka, a seven year old girl, was raped and murdered by her neighbour who was a convicted sex offender, (Quindlen, 1994).

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from sexual predators (Finkelhor & Ormrod, 2000), and that offences of this type are frequent and likely occurrences - especially by former offenders (Zgoba, 2004). It is in response to this "moral panic" (Cohen, 1972) that legislation and the resultant Registers have been created to protect children, however, it must be questioned whether either are appropriate and useful.

In New South Wales in Australia, the Child Protection (Offenders Registration) Act (2000) is designed to assist police in supervising sex offenders in the community. Registrable individuals are obliged to report to police once per year, as well as informing police of any changes to relevant personal information.

Sex offender registration is theoretically designed to fulfill two main roles. First, to maintain police records of where convicted sex offenders live and work, so as to hasten the apprehension of offenders should an offence occur. Secondly, to act as a deterrent (Elbogen, Patry & Scalora, 2003; Letourneau et al., 2010).

The Child Protection Register in New South Wales is predicated on two main assumptions:
That sex offenders reoffend at a very high rate; and
That by providing police access to information about where they live, work and so on the community will be safer from sex offenders.

As discussed previously, the rates of reoffending for sex offenders for further sex offences are one of the lowest of all crimes (e.g., Bonnar-Kidd, 2010; Levenson et al., 2007) thus, calling the first assumption into question.

With regard to the second assumption, the extant literature has examined the ability of the Register to reduce recidivism by comparing groups of offenders who were convicted and sentenced prior to the introduction of the registration laws against groups of offenders matched on critical variables, who were convicted and sentenced following the introduction of the legislation. The research (e.g., Schram & Milloy, 1995; Zevitz, 2006) has not found any significant difference in rates of recidivism prior or post-Register across groups, or any demonstrable impact of the Register as a deterrent.

Other research has looked at what the impact of the Child Protection Register actually is for the offenders and their experience of risk management. Seidler (2010) interviewed registered sex offenders and Comartin, Kernsmith and Miles (2010) have looked at the impact on the families of registered sex offenders. Seidler's research involved qualitative methods that investigated the sex offenders' experiences of the Register. She found that some male sex offenders in Sydney, Australia reported feeling that the Register may increase their risk of reoffending, due to difficulties for them in finding employment, stable housing, education and other forms of social support. Comartin and colleagues held a focus group with families of registered juvenile sex offenders and found that the families of registered sex offenders struggled to integrate into society after their children were Registered. They also found that the parents and extended families of registrees were afraid for the offenders, for their physical safety, false accusations or unintentional non-compliance that could become problematic. Taken together, these studies suggest that the Register is costly in terms of the social and emotional community reintegration of offenders post-release. Further, these studies suggest that the offenders who are subject to registration and their families often face stigmatising, prejudice, harassment and sometimes physical retribution through violence because of their offending. This may in turn affect their reintegration into society.

Given that in the majority of cases, child sexual offenders are known to the victim, either as a relative, family friend or trusted person, regardless of a Register or notification, those who need to know about the offending often already know and may be able to put strategies in place to protect the children (Coleman, 2006). Thus, the Register may seem particularly ineffective considering that its development was based, at least partly, on the assumption that people can protect themselves from becoming victims by removing themselves from the presence of sex offenders (Vandiver et al, 2008). Tewkesbury and Jennings (2010) argued that aside from being a "feel good" policy (see also Vandiver et al., 2008), there is no demonstrable value for registration and notification practices in terms of reducing offending.

There has been little research into community perceptions of Registers of this type. Some studies have examined whether the community is familiar with registration and whether the community thinks notification is "important" (Phillips, 1998). Other research has examined community perceptions of different sex offences and which should be subject to notification as well as public perceptions of the risk posed by sex offenders for reoffending (Kernsmith et al., 2009; Levenson et al., 2007). Overall, this research has found that the overwhelming majority of individuals feel that such Registers are important. This research also indicates that there are differences in how certain sex offenders are perceived by the public, such as "paedophilic" or "incest" rapists being seen as more serious than statutory rape-sexual intercourse between a legally consenting older party and a minor (Levenson et al. 2007). Further, Phillips (1998) found that in a study of 400 members of the public in Washington state, more than 50% of parents reported that they had not put in place any strategies to protect their children, even after being notified that a sex offender was living nearby. This suggests that not only does the Register not provide a barrier to reoffending, it also does not

appear to influence parents with such knowledge to take extra measures to protect their children.

Some research has suggested that that there may be a difference in public perception of sex offender registries and notification as a function of age. Phillips (1998) found that members of the public in their mid-30s had stronger opinions in favour of registration and notification and were more likely to endorse punitive strategies than any other age group, regardless of gender. Further, it was speculated that this was because respondents in their mid-30s were most likely to have their own, or have relationships with, young children. Other research (e.g., Levenson et al., 2007), however, failed to find this relationship. The current research was designed to explore this in the local context. Further we investigated whether there was a relationship between strength of opinions and presence of young children for whom the respondents are responsible, even if not related to the respondent. Furthermore, Kernsmith, Craun and Foster (2009) recommended that research should investigate the relationship between gender, victimisation and strength of convictions about registration. Our research investigates these issues in an Australian setting.

Methodology

The current study used a questionnaire to investigate the relationship between demographic variables and perceptions of the Child Protection Register in Sydney. The demographic variables collected included age, gender, occupation, presence of children with whom the respondent interacted on a regular basis, age and relation of the children to the respondent, history of being offended against and the type of offences. The questionnaire also measured the respondents' knowledge of the Child Protection Register or treatment for sex offenders; and their opinion regarding the impact of the Register on safety. It also included a series of questions designed to assess the respondents' knowledge about the workings of the Child Protection Register, and their opinions regarding the adequacy of the Register and how it could be made more effective with a view to child protection.

Aims

a) To fill a gap in the literature by examining public attitudes about child protection.
b) To understand public opinion regarding the Child Protection Register.
c) To investigate the relationship between opinions about child protection and the Register and demographic variables.

The researchers formed the following four hypotheses for this study:

- That members of the public would not be well informed about the Child Protection Register and how it operates.
- That they would believe that it offered protection from child sex offenders.
- That those with young children (related or otherwise) would be more likely to endorse punitive strategies for punishment of sex offenders than those with no children.
- That there would be no gender differences in attitudes and knowledge about the Register.

Participants

The inclusion criteria for participation in this study were that participants were over 18 years old, spoke English sufficiently well to give informed consent and complete the questionnaire and understand the voluntary nature of the study. A total of 111 participants' data were analysed.

Participants were recruited by multiple means, including approaching individuals on the street and asking if they would be interested in participating and a "snowball" approach of contacting individuals known to the respondents and researchers and asking if they would be willing to participate. A varied sample was sought.

Results

The sample had a mean age of 38 years with a range from 19-68 with around 30% male and 70% female. In our sample, 28% were single, 62% were married or in a defacto relationship, 10% were either divorced, widowed or 'other', such as engaged or separated.

In terms of employment, we coded 'occupation' based on the NSW census categories and Table 1 demonstrates the rates at which different categories were endorsed. Table 2 demonstrates the breakdown of education brackets in our sample. In sum, our sample is better educated than the general population, given that according to census data in 2010, there were 40% of 15-64 year olds holding either a Bachelor degree or higher (23%), or a basic or skilled vocational qualification (TAFE; 17%). In comparison, almost one third of the population, according to the 2010 census, has completed Year 11 or lower as their highest level of educational attainment.

Table 1. *Participant occupations*

Occupation	**% (n = 111)**
Agriculture	0.9
Electricity, gas, water and waste	0.9
Construction	5.5
Wholesale trade	2.8
Retail trade	8.3
Accommodation and food	0.9
IT	0.9
Finance and insurance	0.9
Science and tech	12.8
Admin	14.7
Public safety	2.8
Education	13.8
Health care	24.8
Arts and Recreation	1.8
Animal services	0.9
Other	7.3

Table 2. *Participant educational attainment*

Education (highest level)	% (n = 111)
Primary School	0.9
Year 8 or 9	0.9
Year 10 or equivalent	9.9
Year 11 or equivalent	4.5
Year 12 or equivalent	13.5
TAFE/Bachelor degree	55
Post-graduate	15.3

In regards to the presence of children in our respondents' lives, Table 3 illustrates the frequencies and Table 4 illustrates the relationships of the children to the respondents. 'Other' included relationships such as nieces, nephews, foster children or children in their care such as for school teachers. 42.3% of our sample reported having been a victim of a crime at some time in their lives. We coded crime types based on the Bureau of Crime Statistics and Research (BOCSAR) classifications (see Table 5 for a full list).

Table 3. *Number of children involved in life*

Child Involved	**% (n = 111)**
None	37.8
1	11.7
2	23.4
3	7.2
4+	19.8

Table 4. *Relationships with the children in life*

Child Relationship	% (n = 70)
Natural	58.6
Stepchildren	2.9
Grandchildren	12.9
Great grandchildren	1.4
Other	24.3

Table 5. *Type of crimes participants have experienced*

Crime Type	% (n = 45)
Assault (Domestic Violence)	4.4
Assault (Non DV)	17.8
Sexual assault	13.3
Robbery without a weapon	4.4
Robbery with a weapon	2.2
Break and Enter dwelling	22.2
Motor vehicle theft	4.4
Steal from motor vehicle	2.2
Steal from dwelling	4.4
Steal from person	17.8
Malicious damage to property	2.2
Mixed offences	4.4

We tested Hypothesis A by examining the frequency with which people believed offenders checked-in with police. At the same time, we also examined whether they believed that was an appropriate frequency and the degree to which people rated the Register as making children safer (on a 5 point Likert scale) thus addressing Hypothesis B. In our sample, 65% of respondents thought that the required check-in frequency for sex offenders (which in reality is once per year) is

appropriate and adequate. However, 68.2% thought that the check in would be somewhere between daily and monthly. On a five-point Likert scale, the average rating for child safety because of the Register was 3, compared with 5 for incarceration, perhaps demonstrating that the public does not feel sex offenders can be trusted with their children. Further, 8% (n = 8) believed that in Australia we have public notification, which was incorrect at the time of the data collection (compared to recent initiatives in Western Australia).

The questionnaire included open questions about the management of sex offenders and the responses to these items was coded by the researchers. Responses included punitive measures such as castration, indefinite incarceration, 24 hour supervision/monitoring and in some cases, the death penalty or "killing all first born boys". In relation to Hypothesis C in our sample, 31.2% (n = 24) of respondents think that the government of New South Wales should use punitive measures on sex offenders and 29.9% (n = 23) thought that sex offenders cannot be prevented from reoffending. Given Phillips (1998) found that those in their 30s were more likely to endorse punitive strategies, we wanted to explore this link further. We also speculated that it may be related to the presence of young children in the home or potentially having a relationship with a child or children that may be significant. We examined associations between endorsement of punitive punishment strategies and age, sex, education, whether or not they were victims of a crime and whether or not children were living with them. We found that punitive responses were significantly more common in respondents who lived with children $\chi^2(1)$, 4.23, p = .039), with only 24.1% (n = 13) of respondents with no children living with them suggesting punitive responses, compared to 47.8% (n =11) of respondents with children living with them offering punitive responses. This significant difference did not extend to people who simply responded they had children involved in their lives.

Further analysis assessed the connection between the relationship of the child living with the respondent and punitiveness towards sex offenders. We found a non-significant trend towards less punitiveness the more distant the relationship of the respondent to the child. Approximately 40% of respondents with natural children suggested punitive responses, 20% of those with grandchildren suggested punitive responses and 25% of those with 'other' relationships to children suggested punitive responses (other included nieces, nephews, cousins etc). When the categories were collapsed to "natural children" and "other children", the non-significant trend continued with 40% of those with natural children as compared to grouped result of 27% of those with 'other relationships' suggesting punitive responses.

The participants were also asked to estimate the one year reoffending rate for low, moderate and high risk sex offenders on a scale of 0-100%. Results found that for a moderate risk sex offender, the sample was evenly divided on the estimations of risk (see table 6). For a high risk offender, however, just under 70% of the sample thought that there is a 70-100% risk of reoffending within one year. Comparing participants on estimates of risk by punitiveness, we found that for low risk and high risk respectively, there were significant differences in the estimates of risk for punitive versus non-punitive respondents (see table 7). There were, however, no significant relationships between the presence of children and estimation of risk.

Table 6. *Risk Estimates I*

Risk Estimations Moderate Risk	% sample with this estimation
<40%	30%
40-60%	30%
>60%	30%

Table 7. *Risk Estimates II*

Mean risk estimates	Low Risk** (mean%/sd)	Moderate Risk (mean%/sd)	High Risk** (mean%/sd)
Punitive Responses	40.8/30.35	62.29/25.66	90/18.06
Non-punitive	24.02/22.89	47.65/23.71	73.73/27.63
T-values	T(73) = 2.66; p = 0.009	T(73) = 2.43; P = 0.18	T(65.21) = 3.05 P = 0.003

**Results are significant at 0.01 level
*Results are significant at 0.05 level

With respect to Hypothesis D, we found no evidence of gender differences in any of the analyses. Analysis of gender and punitiveness returned indicated no difference between male and female respondents in terms of endorsement of punitive responses. In terms of risk estimations, there were no significant differences between males and females. See table 8 for results.

Table 8. *Risk Estimates III*

Risk Estimates	Low Risk (mean)	Mod Risk (mean)	High Risk (mean)
Male	25.45	49.22	77.19
Female	29.81	52.60	78.90
T-values	T(107) = -.812 p = .419	T(107) = -.646 P = .519	T(107) = -.314 P = .754

Discussion

In sum, the results from this study suggested four main findings:

•Participants were ill-informed about the Register and how it is used.

•Participants typically overestimated risk for sex offender recidivism.

•Those who suggested punitive strategies for management of sex offenders made risk estimates that were significantly higher than those who did not endorse punitive strategies.

•Those with children were more likely to endorse punitive strategies than those without children.

These findings were consistent with our hypotheses and suggested that the general community in Sydney are unaware of the Register and how it works. They tend, however, to see it in a positive light and sex offenders negatively; and simultaneously overestimate risk for reoffence by such offenders.

It is not surprising that the public is poorly informed about the Register and how it works. Myths and misperceptions about sex offenders and offending abound in public discourse (Richards, 2011). Similar results have been found by Levenson and colleagues (2007). The implications of this may include the use of increasingly more restrictive laws to protect the public from sex offenders in order to appease the community. Also, the use of restrictive measures on low risk or non-violent offenders may drain resources while diverting attention away from those who would actually benefit from more intervention (Levenson et al., 2007).

Mills and Kroner (2006) also found that baseline estimates for risk were over-inflated by lay people. Given estimates of reoffending rates over time suggest that reconviction rates do not exceed around 25-40% over 15-25 years (Hanson and Bussiere, 1998), even taking into account low rates of reporting and conviction (Bachman, 1998; Taylor & Gassner, 2010), 70-100% reoffending rates over one year are an over-estimation, still allowing for the greater emotional valence that such crimes have in people's minds (see Mills & Kroner, 2006).

Research into fear of crime suggests that while the correlation is modest, there is evidence of a correlation between fear of crime and punitive attitudes (Maruna, Matravers & King, 2004; Roberts & Stalans, 1997). Tyler and Boekmann (1997) posit a theory that those who feel that there is a danger to themselves or their communities are more likely to have punitive attitudes towards criminals. Logic follows that those who overestimate risk the most would be the most punitive, as they would be more inclined to be worried about further harm, as they believe it is significantly more likely. In our sample, those who offered punitive strategies for sex offender management had significantly higher estimates of reoffending rates. As per our finding that those with children were more likely to be punitive, it follows that those with children may be more inclined to punitive attitudes given the overestimations of offender reoffence. It is our contention that those with children are more likely to be emotionally affected by child sex offenders, so these individuals may be more inclined to support more punitive strategies to manage sex offenders.

Our results suggest that community awareness, as represented by our sample, may overestimate the ability of the Register to have an impact on reducing recidivism and thus, protecting the community from sex offenders. The public may have a false sense of security due to the presence of the Register, given the frequency with which people think offenders are reporting to police. These individuals would be "safe" in the knowledge that there are no sex offenders living nearby and any that may be there will be closely monitored by police. We wanted to further examine qualitatively what people felt about the Register, sex offenders and child protection and how they behave in a practical way in regards to this. This research was also conducted and the results are forthcoming.

The belief that the Register is more capable of protecting children than the reality, which the literature tells us is of little actual protective value, if any, is problematic. Child protection strategies such as the Register, are only employable once a child has been harmed. It is the role of people on the front-line, usually the parents or caregivers of the children, to protect them from the real (not imagined) dangers of sexual offenders. Practically, the management of sex offenders should not be left to a Register that is maintained and updated only once per year. The community should also receive practical education on what is and is not acceptable behaviour, who and when to report suspicions and inappropriate behaviour. Parents need to be taught how to monitor their children appropriately and what signs to look out for that may suggest their children have been hurt. Without education, training and support on both sides there will be no adequate solution.

In closing, there some limitations to the findings of this study. First, the collection of data may have involved bias through the researcher being familiar with some of the participants. Secondly, the sample was relatively small and included an inflated proportion of females compared to males. Thirdly, our participants were better educated than the average member of the general population. Further research could examine the pattern of results with a stratified sample.

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An Integrated Theory of Sexual Recidivism

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Abstract

Over the last twenty years, theories of sexual offending have received a great deal of attention in the literature and there have been a number of important developments. While some theories have focused on the identification of specific causal factors, others have brought together a range of factors in the form of integrated models. Theoreticians who work in this field share the common goal of explaining this highly problematic behaviour so that appropriate interventions can be developed. However, it is interesting to note that, to date, the theoretical research has looked primarily at sexual offending per se, rather than sexual *re*offending; thus, there appears to be a gap in the literature. This article seeks to lay out a framework for filling this gap by bringing together two typically disparate bodies of literature; namely, the theories of sexual offending and the risk factors for sexual reoffending.

Introduction

Over the last 20 years several new theories of sexual offending have emerged in the literature. While some theorists have focused on the identification of specific causal factors such as attachment disturbance (for example, Marshall & Marshall, 2010) and negative affect (for example, McCoy & Fremouw, 2010), other researchers have developed integrated multi-factorial models (for example, Ward & Beech, 2006). However, despite a variety of approaches, most theorists agree that sexual offending results from a range of interrelated factors. In other words, it is acknowledged that sexual offending does not have a single cause, but rather arises from a number of complex factors.

It is interesting to note that while there is a growing theoretical literature that has looked at the causes of sexual offending, it appears that to date, no researchers have presented any comprehensive theories of sexual *re*offending. In other words, there do not seem to be any articles which have outlined theories of recidivist sexual offending. While there is plenty of literature that has looked at risk factors for recidivism, these have not been conceptualised in the form of a coherent theory, thus, this is seen as an important area for further theoretical development. As suggested by Kirsch and Becker (2006): "Factors associated with the initiation of sexual offending may not be the same as those that maintain it" (p. 214).

This article aims to develop a theory of sexual reoffending by bringing together the research on theories of sexual offending and the literature that has examined the risk factors for sexual recidivism. The article begins with discussions of various significant theories and then looks at the recidivism literature. It concludes with a description of an integrative model of sexual reoffending. Note that this article builds on an earlier version of this theoretical investigation which was published recently (Thakker & Ward, 2011). This article takes a broader approach to the literature review (incorporating more theories) than the earlier article and leads to a more finely-tuned model.

Theories of Sexual Offending

As mentioned above, most theorists now agree that sexual offending arises from a variety of causal variables. These variables include distal causal factors such as early life experiences (e.g. Marshall, 2010) and genetic predisposition (e.g. Siegert & Ward, 2003) as well as more proximal causal variables such as substance abuse (Hanson & Harris, 2000). Obviously, it is not possible in this brief article to provide a thorough overview and analysis of all of the relevant theories, therefore, the approach taken herein is to include the most influential theories as well as to provide a cross-section of the available theories. Thus, the article covers two theories of child sexual offending (Finklehor's 1984 Precondition Model and Marshall and Barbaree's 1990 Integrated Theory), two theories of sexual offending against adults (Hall and Hirschman's 1991 Quadripartite Model and Knight and Sims-Knight's 2004 Three Paths Model), and one theory of general sexual offending (Ward and Beech's 2008 Integrated Theory.

Theories of child sexual offending

Finklehor's Precondition Model

Finkelhor (1984) suggested that child sexual offending is a result of the presence of four key problems: emotional congruence with children, sexual arousal,

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blockage, and disinhibition. Emotional congruence refers to the idea that individuals who sexually offend against children use children to meet their emotional needs because they have difficulty meeting these needs with adults. The sexual arousal component of the model simply refers to the notion that child sexual offenders find children sexually arousing. The concept of blockage relates to the idea that these offenders have a range of psychological difficulties which make it difficult for them to meet their emotional and sexual needs in the context of intimate relationships with adults. Finally, Finkelhor argued that child sexual offending requires some degree of disinhibition which may arise from a number of factors such as substance abuse or problems with impulse control. One important characteristic of Finkelhor's model, which distinguishes it from the other models that are discussed herein, is that all of the factors are considered to be essential for child sexual offending to occur.

Since its development in the mid 1980's, Finkelhor's (1984) model has been widely cited in the literature. Ward and Hudson (2001) suggested that the model has a number of strengths. For example, they pointed out that it laid out a conceptual framework for research in the field and provided guidance for the development of treatment programmes. However, the model has also been criticised. For instance, Ward and Siegert (2002) asserted that it places too much emphasis on proximal variables and not enough on more distal factors. Furthermore, Ward and Siegert argued that Finkelhor did not provide sufficient explanation of why psychological problems such as blockage and emotional congruence result in sexual activity with children.

Arguably, another problem with Finklehor's model is its lack of flexibility insofar as all four of the conditions must be present in order for child sexual offending to occur. Given the heterogeneity of individuals who commit sexual offences against children, it seems unlikely that they would all present with the same underlying causal pattern. For example, one could conceive of a situation in which a man might sexually offend against a young female without having a preference for sexual activity with a minor. One example would be a man who has a sexual preference for an adult female but targets an underage female when interaction with an adult is not possible. Also, there are many cases of men sexually offending against children when they are in stable intimate relationships with women, although one might reasonably question the quality of such relationships.

Marshall and Barbaree's Integrated Theory

Marshall and Barbaree (1990) proposed that child sexual offending arises from the presence of a range of interacting distal and proximal factors. The distal factors include developmental variables such as problematic parenting (in particular, overly harsh discipline) and physical and sexual abuse. Marshall and Barbaree suggested that exposure to these aversive early life events leads to psychological problems, such as impaired self-regulation and insecure attachment. Then during adolescence, when the individual undergoes significant physical changes, the psychological difficulties which have arisen as a consequence of early life challenges result in a deviation in their sexual development. In particular, they suggested that feelings of anger combine with sexual feelings, which in turn lead to the emergence of sexual aggression. In explaining their theory, Marshall and Barbaree pointed to research that indicates that sex and aggression share the same neural pathways in the human brain.

As mentioned above, Marshall and Barbaree's theory also includes reference to more proximal and contextual factors. For example, they proposed that stress could impact on an individual's ability to cope with a situation, thereby leading to an increase in the likelihood of an offence. Also, they suggested that intoxication might lead to an increase in disinhibition which may also contribute to the tendency for offending. Another, perhaps more obvious factor that they proposed may contribute to an offence is the presence of a potential victim, which may lead to sexual arousal. Furthermore, Marshall and Barbaree mentioned maintaining factors; for instance, they theorised that the sexual gratification that is experienced during the commission of a sexual offence may act as a reinforcer, thereby making reoffending more likely. This is important in considering the precipitants of reoffending.
One of the strengths of Marshall and Barbaree's model is that it looked in detail at the role of early life experiences and considered how these may play out over the life span. Also, by including the concept of attachment, they presented a psychological mechanism that tied together aversive early experiences and later developmental factors. Further, it took a broad and inclusive approach which allowed for some degree of heterogeneity in explaining sexual offending.

As argued by Ward and Siegert (2002), however, the model has a number of weaknesses. One of the key problems is that aggression is conceptualised as playing an important role in child sexual offending. But, while aggression is seen as playing a significant role in rape offences, it is not always seen as playing a major role in child sexual offending. For example, while rape is inherently aggressive (Gudjonsson & Sigurdsson, 2000) child sexual offenders often use means other than violence to coerce their victims, such as bribery and verbal manipulation (Robertiello & Terry, 2007). While one could take the view that all sexual offending against children necessarily involves acts of aggression, this would require a somewhat different definition of

aggression than the one which Marshall and Barbaree appear to be using which seems to be more akin to the sort of aggression which may be seen in a rape offence. Beech and Ward (2004) argued that another problem with the model is that while it does a good job of explaining the onset of adolescent child sexual offending, it is less applicable to offending that has its onset in adulthood because the model suggests that the problematic behaviour should emerge during adolescence.

Theories of adult sexual offending

Hall and Hirschman's Quadripartite Model

As indicated by the name of their model, Hall and Hirschman's (1991) Quadripartite Model identified four key factors that lead to sexual offending against women, namely: offence-related sexual arousal, pro-rape cognitions, affective dyscontrol, and "developmentally-related personality problems". With regard to the first factor – sexual arousal – Hall and Hirschman suggested that the physiology of the sexual arousal that is involved in rape may not be substantively different to that seen in the context of consensual sex (i.e. a rapist does not necessarily have deviant sexual arousal). In explaining this point, the authors referred to research which has shown that sexual arousal to "rape stimuli" is found in both rapists and non-rapists (e.g. Malamuth, Check, & Briere, 1986). Thus, Hall and Hirschman concluded that in terms of explaining sexual aggression, sexual arousal is necessary for rape but not sufficient.

In explaining the second aspect of the model – pro-rape cognitions – Hall and Hirschman (1991) proposed that when individuals experience sexual arousal they cognitively appraise the situation, thereby bringing to bear their attitudes and beliefs about women. Hall and Hirschman argued that such attitudes and beliefs "may be conditioned through cultural or social processes" (p. 664). The third component of the model – affective dyscontrol – refers to the presence of negative emotion which the individual is not able to manage in an adaptive and pro-social manner. Hall and Hirschman suggested that anger and hostility are particularly important in rape offences and comparably less important in explaining child sexual offending; "…sexually aggressive behaviour occurs when these affective states become so compelling and powerful that they overcome inhibitions" (p. 664).

The fourth component of the model – developmentally-related personality problems – refers to the presence of antisocial personality traits which are theorised to result from problematic early life experiences. For example, Hall and colleague pointed out that rapists have often experienced abuse and neglect during their childhood years, have had little if any academic success, and have a history of diverse antisocial behaviour. Thus, similarly to Marshall and Barbaree, Hall and Hirschman suggested that a range of aversive early experiences may contribute to the development of antisociality. Furthermore, the authors proposed that "a personality trait factor could account for the chronicity and severity of sexually aggressive behaviour" (p. 665).

Hall and Hirschman hypothesised that along with the above-mentioned variables, environmental factors also play a role in the commission of a rape offence. For instance, they suggested that the presence of a victim or intoxication with alcohol could increase the likelihood that an offence will occur. In explicating this aspect of their model they stated that an individual who meets the other four criteria and is therefore vulnerable to offend, will be more or less likely to offend depending on the presence or absence of certain environmental factors.

Hall and Hirschman's model has a number of strong points. In particular, it is flexible, as it suggests that the extent to which the variables predominate may differ across individuals. For example, while antisocial personality traits may be prominent in some offenders, in others, sexual arousal may be most significant. Arguably, another positive feature of the model is the inclusion of environmental factors as this assists in explaining why a particular offender decides to offend in a particular situation. Also, another strength which is particularly relevant to this discussion is the mention of chronicity which Hall and Hirschman (1991) link to the presence of antisociality.

One problem with Hall and Hirschman's model is the suggestion that emotional dyscontrol will always be present for offenders to some degree. Arguably, an individual could commit a rape without the presence of negative emotion or might even commit the offence in the presence of a positive emotion (Ward, Hudson, & Keenan, 1998). For instance, the offence might be carried out in a calm and calculated manner with the intention of enhancing the emotion that is already being experienced. Another weakness of Hall and Hirschman's Quadripartite Model is the ambiguity surrounding the personality aspect of the model. The ambiguity generates two key questions: 1) Do early life experiences always exert their influence on the individual via personality? and 2) Can personality problems be present even if there are no problematic early life experiences? This particular aspect of the model seems less clear than the other three components.

Knight and Sims-Knight Three Paths Model

Knight and Sims-Knight's (2004) Three Paths Model contrasts with the other models reviewed as it considers different *pathways* to offending. While it still includes a number of factors that may play a causal role, the model examines how these factors unfold over time. Thus, the

model proposes that the key factors can be arranged in such a way that they form three different pathways. Specifically, Knight and Sims-Knight suggested that experiences of abuse during childhood combined with specific personality characteristics lead to the development of "three latent traits" namely: "…(a) arrogant, deceitful personality/emotional detachment, (b) impulsivity/antisocial behaviours, and (c) sexual preoccupation/hypersexuality." As explained by Knight and Sims Knight (2004), the (a) and (b) groups of traits broadly correspond with Factors 1 and 2 (respectively) of Hare's (2003) approach to the conceptualisation of psychopathy wherein Factor 1 refers to problematic features of emotional functioning and personality and Factor 2 refers to more general antisocial characteristics.

The first pathway of the model begins with abuse (physical and/or verbal), tracks through antisocial behaviour and/or aggression and then leads to sexual offending. The second pathway also begins with abuse but then tracks through the Factor 1-type personality characteristics and aggressive sexual fantasy before culminating in sexual offending. The third and final pathway begins with sexual abuse, tracks through sexual fantasy then through aggressive sexual fantasy and then leads to sexual offending. Knight and Sims-Knight (2004) reported that they tested the validity of the model on two groups of sexual offenders (an adult group and a juvenile group) and a control group (of non-offenders). They concluded that: "The three-path model…not only provided a good fit for the data used to predict sexual coercion in both adult sexual offender and community samples but…also predicted sexual coercion among juvenile sexual offenders" (p. 49).

One of the key strengths of this model is that it considers the relationship between early risk factors and personality types. In doing so, it provides a psychological mechanism for the link between aversive early experiences and sexual offending. While for Marshall and Barbaree (1990) that link was insecure attachment, for Knight and Knight-Sims (2004) the link is the development of problematic personality traits, either psychopathic or more generally antisocial. Another advantage of the model is that it provides a roadmap for the development of treatment as well as preventive interventions.

On the other hand, a possible criticism of the model is that it is too narrow in its approach. It points to abuse experiences (either sexual, physical, or verbal) as being the key early vulnerability factors. However, it seems likely that there are other factors that may also play an important role in setting the scene for the development of psychological difficulties. For example, it may be argued that biological factors, such as temperament, would contribute to the way that children interact with the world, and also, how their parents interact with them. Furthermore, the model is silent on the role of more proximal/situational variables, such as relationship stress and the availability of victims.

A theory of general sexual offending

Ward and Beech's Integrated Theory

Ward and Beech's (2006) Integrated Theory does not focus specifically on either child or adult sexual offending but rather looks at sexual offending in general.

The theory (shown in Figure 1), which is described by Ward and Beech as "a network of causal factors," suggests that there are four general sets of variables that are important in explaining the manifestation of sexual offending. These are: *biological factors* (such as genetic predisposition and neurological development), *ecological niche factors* (such as socio-cultural environment and personal situation), *neuropsychological factors* (such as motivation, emotion, and memory), and *clinical symptoms* (also referred to as state factors). Ward and Beech proposed that the first two groups of factors (i.e. biological and ecological niche) contribute to changes in neuropsychological functioning, which in turn, lead to changes in clinical symptoms. These changes then lead on to the commission of a sexual offence.

As shown in Figure 1, the model is circular, showing a feedback loop, which seeks to explain the maintenance of sexual offending over time (which is of course especially relevant to this discussion). Specifically, Ward and Beech suggested that the action of committing the offence and the after-effects of this (which are encapsulated in the ecological niche factors) along with the neurological and clinical factors form a "positive feedback loop" which may serve to maintain and even strengthen the sexual behaviour. In providing a summary of their model, Ward and Beech (2006) stated, "…in our theory brain development (influenced by biological inheritance and genetics) and social learning interact to establish an individual's level of psychological functioning" (p. 23).

One of the advantages of Ward and Beech's Integrated Theory is its scope; it takes an inclusive approach and includes a diverse range of variables, from early biological factors to social and environmental factors. It also provides accounts of both the initiation and maintenance of sexual offending over time. Furthermore, by including a variety of factors it allows for a degree of heterogeneity in the development of problematic sexual behaviour. Perhaps most unusual, in contrast to other models, is the inclusion of biological and neurological variables, both in terms of the initiation of the behaviour and the maintenance of it. The suggestion here is that behaviour, experiences, and

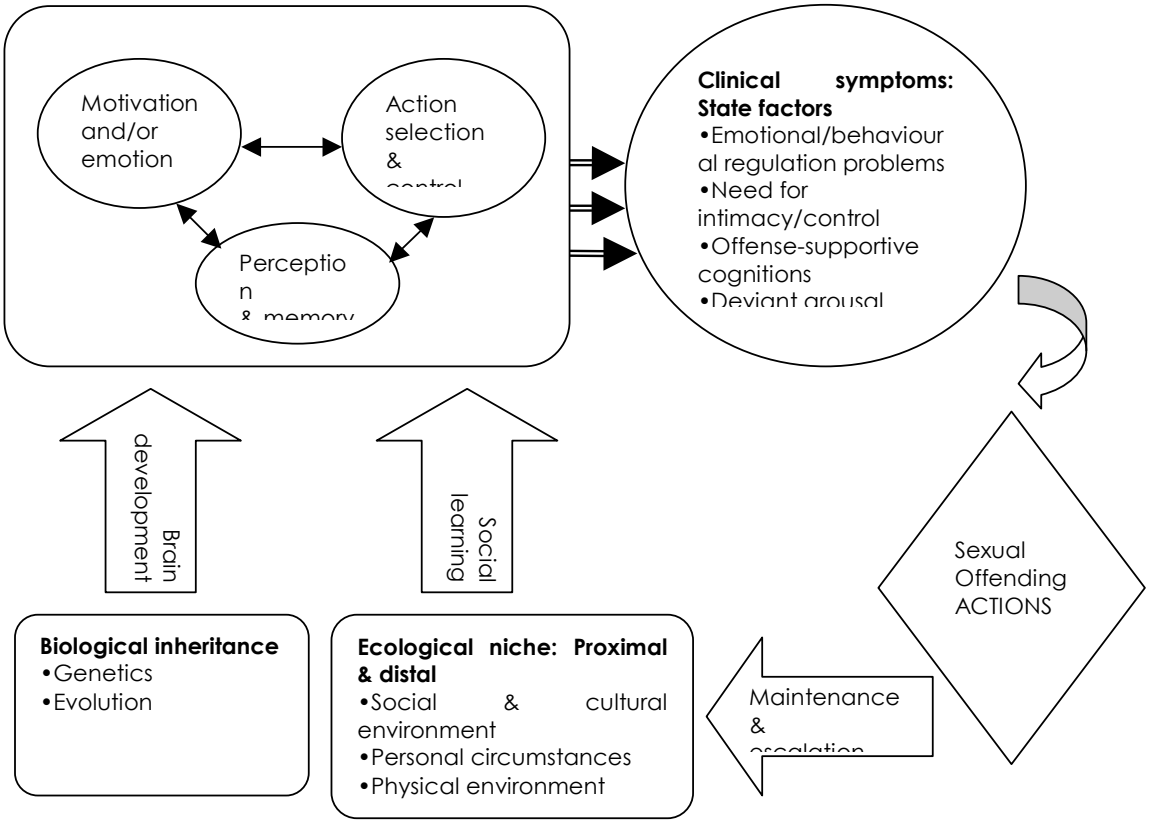

Figure 1. *Ward & Beech's Integrative Theory of Sexual Offending*

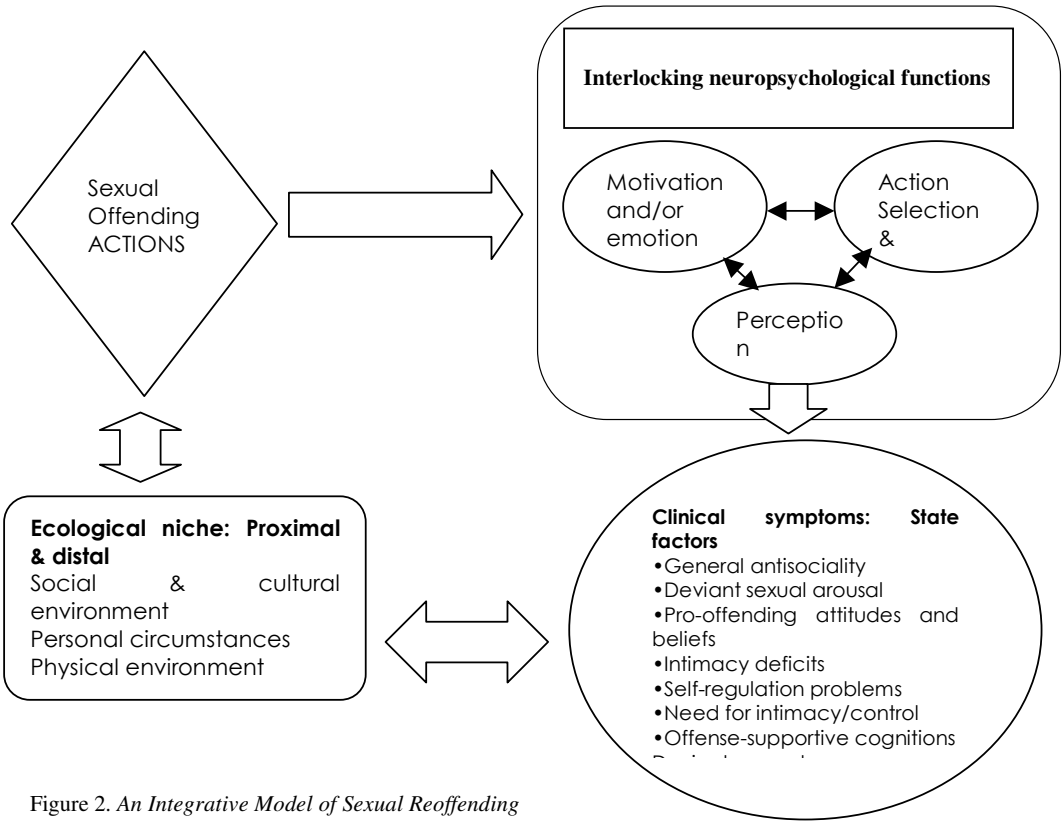

Figure 2. *An Integrative Model of Sexual Reoffending*

social contexts can lead to neurobiological changes. In this way the model mirrors some of the theories that have been developed in the substance abuse area, which [JT1]incorporate neurobiological changes. For example, it is now widely understood that the addictive qualities of many substances arise out of the functioning the dopamine reward pathway (Durrant & Thakker, 2003). Similarly, Ward and Beech argue that sexual offending can arise out of, and also feed back into, various neural pathways in the brain.

One criticism of Ward and Beech's (2006) model is that in contrast to the other models outlined herein, it is quite complex. One could argue that in taking an inclusive approach, it has become unwieldy. However, as stated by Ward and Beech the model was presented as a "framework for integrating many of the factors identified in research and theory as being important in the development of sexual offending" (p. 61). Thus, arguably, in order to incorporate all of the identified factors, it would have been necessary to create a detailed and comprehensive model.

Combining the models

In this section, the five aforementioned models are combined in order to create one overarching model which can then be used as the framework for the development of a model of sexual recidivism. Analysis of Ward and Beech's (2006) integrative theory (depicted in Figure 1) shows that it essentially subsumes the other four models that are outlined herein, thus it provides a useful way of visually summarising the models. Finkelhor's four pre-conditions are essentially clinical or state factors: emotional congruence, sexual arousal, blockage, and disinhibition all fit neatly into this category. However, the latter is probably also affected by ecological niche factors. For example, if an individual attends a social gathering and drinks heavily, then he may offend due to an increase in disinhibition. Thus, this factor may be less stable than some of the other factors and more easily influenced by the environment.

Marshall and Barbaree's theoretical approach fits most easily into the bottom left-hand portion of the model insofar as it is more concerned with the development of sexual offending over time. Marshall and Barbaree focus mostly on the ecological niche aspect of the model wherein socio-cultural factors and personal circumstances lead to problematic neuropsychological functioning. Like Finkelhor's model, the theory proposed by Hall and Hirschman essentially refers to the clinical or state factors that are placed in the top right hand corner of the model. Sexual arousal, cognitions, affective dyscontrol and personality characteristics all fit easily into this category. Knight and Knight-Sims' model is more broad-based and fits into several aspects of the integrated model. The abuse aspect of their model would fit into the distal ecological niche component which is connected to neuropsychological functioning and clinical factors via social learning. The other personality factors and the offence-related sexual fantasy would fit with the clinical factors in the top right-hand corner.

It can be reasonably concluded that Ward and Beech's conceptualisation of sexual offending incorporates the key features of the other models, although the other models provide extra detail in some components. For example, Finklehor's, Marshall and Barbaree's, and Hall and Hirschman's approaches assist in fleshing out the detail in the clinical symptoms component. Also, while Knight and Sims Knight's and Marshall and Barbaree's approaches are consistent with the integrative model they also provide some extra detail about specific pathways that connect some of the key variables.

It is useful to note at this point what these theories say about sexual reoffending. According to Marshall and Barbaree (1990), the experience of sexual gratification will make reoffending more likely. This is consistent with the integrated model, as the actions surrounding the offence can lead to an escalation in the offending. According to Hall and Hirschman, chronicity in offending is linked to the presence of antisocial personality traits. This idea is also consistent with the integrative model; antisociality would fit into the category of clinical or state factors which form part of the feedback loop that contribute to further offending. Thus, the integrative model provides a useful framework for developing a theory of sexual reoffending.

The following section looks more closely at the risk factors for recidivism and then combines these with Ward and Beech's integrative model in order to develop a theory of sexual recidivism.

Risk Factors of Recidivism

Hanson and Morton-Bourgon (2005) conducted a meta-analysis of the factors that are associated with sexual reoffending and they found that there appear to be a number of relevant variables. Perhaps most importantly, their analysis showed that the two most significant characteristics were sexual deviance and general antisociality. However, they also identified a number of other important factors, namely, preoccupation with sex, impulsivity, intimacy deficits, unstable lifestyle, and pro-offending attitudes. Hanson and Morton-Bourgon also report that those who sexually reoffend tend to display some of the features seen in general offenders, such as early behavioural problems, interpersonal violence, and having a high number of sexual partners. The researchers also state that evidence suggests that some sexual offenders use sexual fantasies and sexual offending as a way of managing stress, thus

suggesting that reoffending may be more likely to occur in certain situations. The following sections provide a brief overview of the literature in all of the risk areas that have received at least some empirical support.

General antisociality

Hanson and Morton Bourgon (2005) use the term "antisocial orientation" to refer to a range of antisocial traits, such as impulsivity and a tendency for rule violation. They propose that an antisocial orientation may contribute to sexual reoffending in a variety of ways. Specifically, they propose that it may lead a person to 1) be willing to harm other people, 2) believe no harm is being caused, or 3) feel that they cannot control their behaviour. Other studies that have explored the connection between antisociality and sexual reoffending have taken a variety of approaches to conceptualising and measuring antisociality.

Sreenivasan, et al. (2007) measured "prison terms and parole violations" while Roberts, Doren, and Thornton (2002) assessed general criminality by quantifying "any prior burglary" and "any prior nonsexual assault." What both studies found, in spite of their differing approaches to measuring general antisociality, was that general antisociality had a close association with sexual recidivism. In contrast, Boccaccini, Murrie, Hawes, Simpler, and Johnson (2010) used the Personality Assessment Inventory (PAI; Morey, 1991) to explore the connection between antisociality and "sexually violent" recidivism. They found that while the PAI was a good predictor of general and violent recidivism, it did not predict sexually violent recidivism.

As mentioned above, Knight and Sims-Knight (2004) proposed that the presence of psychopathic personality traits may be an important factor in the offence pathway for some sexual offenders. Such traits have also been explored in the recidivism literature. For instance Olver and Wong (2006) examined the role of psychopathic traits in sexual recidivism using the Psychopathy Checklist – Revised (PCL-R; Hare, 2003). They found that the PCL-R "was a weak predictor of sexual recidivism" (p. 65). They also reported that mixed offenders (i.e., those with at least one child and one adult victim) and rapists received higher psychopathy scores than incest offenders and child sex offenders. Another study (Serin, Mailloux, & Malcolm, 2001) assessed the separate associations of Factor 1 and Factor 2 with sexual recidivism and found that only Factor 2 was associated with this type of recidivism.

Taken together, these studies suggest that general antisocial tendencies may be associated with sexual reoffending, although perhaps not to the extent that they are associated with general reoffending. Furthermore, in terms of psychopathy, it appears that sexual recidivism is more strongly related to the Factor 2 characteristics (such as a tendency for general law breaking) than to Factor 1 characteristics (such as grandiosity and superficiality).

Deviant sexual arousal

As outlined above, Hanson and Morton-Bourgon (2005) reported that deviant sexual arousal was one of the two key factors that is associated with sexual reoffending and this appears to be supported by the available research. For instance, Roberts et al. (2002) investigated the factors associated with sexual recidivism and found that offence-related sexual arousal was a key factor. Note that the authors measured sexual deviance by assessing prior sexual offences, noncontact sexual offences, and the presence or absence of male victims; all three of which are risk factors in the Static 99 sexual recidivism measure (Hanson & Thornton, 2000). In contrast, Serin et al. (2001) used phallometric assessments to measure deviant sexual arousal and concluded that problematic sexual arousal is closely associated with sexual reoffending. Specifically, they reported that there was a positive correlation between the presence of deviant sexual arousal and rates of reoffending. They also found that deviant sexual arousal was associated with a shorter time until the commission of a further offence.

Similarly, Sreenivasan et al. (2007) analysed a range of risk factors for sexual reoffending and found that sexual deviance was an important risk factor. However, it is worthwhile noting that out of an array of offence variables, including stranger offence, non-related offence, number of victims, and multiple victim types, only the latter was found to be significantly related to sexual reoffending. Olver and Wong (2006) examined the relationship between deviant sexuality and sexual recidivism using the Violence Risk Scale: Sexual Offender Version (VRS:SO; Wong, Olver, Nicholaichuk, & Gordon, 2004). This scale has five items that comprise the Sexual Deviance factor, namely: Sexual Deviant Lifestyle, Sexual Compulsivity, Offence Planning, Sexual Offending Cycle, and Deviant Sexual Preference. Olver and Wong concluded that deviant sexual arousal plays a significant role in sexual recidivism.

Some researchers have explored the connection between particular aspects of problematic sexual functioning and sexual reoffending. For example, research indicates that a tendency to be preoccupied with sex is associated with sexual reoffending (Cortoni, 2009; Mann, Hanson, & Thornton, 2010). As noted by Långström and Hanson (2006), individuals who are sexually preoccupied typically feel dissatisfied with their sexual functioning even though they may engage in unusually high levels of sexual activity. Thus, individuals who are preoccupied with sex may remain preoccupied even after engaging in sexual activity.

Sexual sadism has also been explored in relation to sexual recidivism. For example, Kingston, Seto, Firestone, and Bradford (2010) assessed the degree to which three indicators of sexual sadism (namely, "index sexual violence, sexual intrusiveness, and phallometrically assessed sexual arousal" p. 574) were able to predict recidivism. They found that all three of the indicators of sexual sadism were significantly related to sexual recidivism, and further, that phallometry-assessed sexual arousal was a particularly powerful predictor.

Overall, the research suggests that deviant sexual arousal plays an important role in sexual reoffending. Furthermore, according to several of the researchers mentioned herein, it may be a particularly important risk factor. Cortoni (2009) states that recidivist sexual offenders tend to see sexual activity as particularly important in comparison to other aspects of their lives and that they also have unusually strong sexual urges. This is an interesting observation which may go some way towards explaining the relationship between deviant sexual arousal and sexual recidivism.

Attitudes and beliefs

As stated above, in their meta-analysis of the risk factors for recidivism, Hanson and Morton-Bourgon (2005) found that offence-related attitudes and beliefs were an important factor. One of the concepts which is often referred to in discussions of attitudes and beliefs is the term "cognitive distortion", which has been described as a belief that sits on the borderline between cognition and motivation (Mihailides, Devilly, & Ward, 2004). Essentially, these are beliefs that an offender uses to support his or her offending. For example, a cognitive distortion might provide a justification for the offence or serve to minimise its seriousness. According to Cortoni (2009), research has shown that cognitive distortions play a fundamental role in sexual offending. Further, Cortoni states that "an overall predisposition to be tolerant of sexual offending is related to sexual recidivism" (p. 44).

However, with regard to the issue of sexual reoffending, the literature is less clear. For example, a recent review of the risk factors associated with sexual recidivism (Mann, Hanson, & Thornton, 2010) determined that the association between pro-offence attitudes and the risk for reoffending varied across contexts. Specifically, Mann and colleagues reported that while there was a clear association in offenders who were assessed in treatment settings, there was no association in those who were assessed in "more adversarial contexts" (such as those who were under community supervision orders). Mann et al. point out that this finding is consistent with the findings of other similar studies and they suggest that further research is required in order to clarify the relationship between offence-supportive attitudes and sexual reoffending.

Hanson and Harris (2000) carried out a comprehensive study of the dynamic risk factors that are associated with sexual recidivism and they found that there was a significant difference in attitudes between recidivist sexual offenders and non-recidivists. Specifically, findings showed that reoffenders were significantly more likely to justify their offending and to hold beliefs of entitlement. These findings are consistent with those of a more recent study by Pemberton and Wakeling (2009) which explored the presence of beliefs of entitlement in a range of offender types, including child sex offenders, rapists, and sexual murderers. They found that beliefs of entitlement (such as "men need more sex than women do" and "everyone is entitled to sex") were endorsed by a range of offender types. Note, however, that this study looked at sexual offenders in general, rather than sexual reoffenders. Thus, it does not add weight to the suggestion that problematic beliefs play a role in sexual recidivism.

One particular cognitive distortion that is commonly seen in sexual offenders is the denial of one's offending (Thakker, Collie, Gannon, & Ward, 2008). Given the fact that sexual offending is viewed by most in society as a particularly pernicious behaviour, it is perhaps not surprising that many offenders deny that they have done what they were accused or convicted of. Even when the evidence is stacked against them, many will continue to proclaim their innocence in an attempt to preserve relationships and/or their social standing. Yates (2009) conducted a review of the literature on denial with a view to determining whether denial contributes to recidivism. Yates concluded that research to date "does not clearly establish denial as a risk factor, or suggests that if it is a risk factor, it is a relatively minor one among a specific group of low risk offenders" (p. 195).

Overall, as mentioned above, it is unclear to what extent pro-offence attitudes and beliefs play a role in sexual reoffending. It appears that offence-supportive beliefs might contribute to sexual recidivism and that beliefs of entitlement may be especially significant. However, further research is needed in order to clarify the issue. In particular, it would be helpful if future research could focus on the role of denial in sexual recidivism.

Intimacy deficits

In their review article, Hanson and Morton-Bourgon (2005) came to the conclusion that intimacy deficits are a risk factor for sexual recidivism. Similarly, several studies have found that problems with intimacy (such as relationship conflict or not having a partner) are significantly more common in recidivist sexual offenders than in non-recidivists (e.g. Hanson and Harris, 2000; Mann et al., 2010). Mann and colleagues

propose that in some cases a lack of any relationship history is associated with unusual sexual interests while a history of problems in intimate relationships may be associated with problematic patterns of attachment. Thus, sexual recidivism may be related to a variety of intimacy-related problems.

Cortoni (2009) suggests that along with intimacy deficits, sexual recidivists also tend to have more general social difficulties. This is consistent with the work of Marshall (2010) who proposes that loneliness may be a particularly important aspect of intimacy deficits in sexual recidivists. In explicating his theory, Marshall argues that the most pertinent aspects of loneliness among these offenders is a feeling of being "permanently alienated from others" (p. 77) and an inability to establish and maintain intimate relationships. In explaining the origins of these sorts of intimacy deficits, Marshall points to early attachment problems and suggests that they can probably be traced back to an individual's childhood years.

As noted by Marshall (2010), there is very little research available that has examined the role of intimacy problems, including loneliness, in sexual offenders. Also, Marshall observes that the literature which has explored the issue has not adequately addressed the question of whether intimacy-related difficulties typically pre-date an offender's initial offence or arise following it.

One particularly important aspect of intimacy problems in relation to child sexual offenders, is the tendency to feel more comfortable with children. In their meta-analysis, Hanson and Morton-Bourgon (2005) found that emotional identification with children was an especially important risk factor for recidivism among child sex offenders. Similarly, Knight and Thornton (2007) reported that a propensity to connect emotionally with children was associated with further offending among those who offended sexually against children. As explained by Mann et al. (2010), child sexual offenders may feel more at ease in the company of children, may find that they communicate more readily with children, and may believe that they themselves have childlike qualities. In some instances, offenders may assert that their sexual activity is founded on mutual feelings of romantic love.

As concluded by Marshall (2010), there is a need for further research in regard to the role of intimacy problems in relation to sexual reoffending. Nonetheless, it is worth noting that three comprehensive review studies (mentioned above) have come to the conclusion that intimacy deficits play an important role in sexual reoffending. Furthermore, in terms of research to date, there is some evidence that loneliness and emotional identification with children (for child sex offenders) may be two particularly significant aspects of intimacy problems that are important in sexual recidivism.

Deficits in self-regulation

As stated by Cortoni (2009), self-regulation "…refers to the offender's ability to self-monitor and to inhibit impulsive, irresponsible and rule-breaking decisions" (p. 47). Research has found that individuals who display antisocial personality traits have a tendency for impulsivity and often have problems with self-regulation. (Andrews & Bonta, 2003). Thus, the role of these phenomena in various types of criminal activity has been widely explored in the literature. In their meta-analysis, Hanson and Morton-Bourgon (2005) concluded that self-regulation problems have a strong association with risk for sexual reoffending. With regard to impulsivity, Mann et al. (2010) investigated what they termed "lifestyle impulsiveness" and found that it was related to sexual recidivism.

Research by Hanson and Harris (2000) examined the relationship between sexual reoffending and various psychological problems and reported that reoffenders were more likely than non-reoffenders to experience negative emotions immediately prior to their re-offence. Furthermore, they reported that anger had an especially strong association with recidivism. This suggests that problems with emotional regulation and in particular, anger management, may play a role in sexual reoffending. However, a recent review by McCoy & Fremouw (2010) of the relationship between negative affective states and sexual offending found that the relevant literature did not support the idea that negative emotion contributes to such offending. However, it should be noted that this review considered sexual offenders generally and did not look specifically at those who sexually reoffend.

Mann et al. (2010) suggest that there is some evidence that sexual reoffenders have difficulty managing negative emotions (such as anxiety and anger) and they refer to this "dysfunctional coping" as a "promising risk factor." Thus, in their view, while the evidence supporting this association is limited, it is highly suggestive that there is an association. It would certainly seem that it is an area worthy of further research.

Other factors

Several other risk factors for sexual recidivism have been investigated by researchers. A literature search revealed that two factors that have perhaps received the most attention are empathy deficits and low self-esteem. However, due to the fact that there is comparatively little research available on these variables, they have not been included in this discussion. Note that the five factors that have been covered are simply those that have been examined in sufficient detail to allow tentative conclusions to be drawn.

An Integrated Theory of Sexual Reoffending

Given that, as proposed above, Ward and Beech's integrative model incorporates the other more specific models, it is a useful framework for developing a theory of sexual recidivism. An adaptation of the model is shown in Figure 2. Given the focus on reoffending, the components of the model have been moved around so that the process begins with a sexual offence. Also, the arrow labelled maintenance and escalation has been removed because the entire model is concerned with on-going offending. Further, the early life biological factors have been removed leaving the feedback loop. Another modification is that the key factors that have been identified as probably playing a role in sexual recidivism have been added in the clinical symptoms component. These factors are: general antisociality, deviant sexual arousal, problematic attitudes and beliefs, intimacy deficits, and problems with self-regulation.

As shown in the model, the sexual action is connected to clinical symptoms via the neuropsychological functioning. This illustrates the idea that the brain needs to process the details of the event before the event is able to influence such variables as deviant sexual arousal and intimacy deficits. Thus, similar incidents could have different impacts on the individual depending on how he or she interprets them. For example, offenders may pay specific attention to different aspects of the offence. While one offender may notice a victim's fear response, another may notice their own sexual arousal.

Another important aspect of the model is the proposed two-way link between the ecological niche component and the clinical symptoms. This highlights the idea that clinical phenomena may impact on an individual's environment. An example of this link would be an offender's choice of residence; his or her pro-offending attitudes and beliefs may influence where s/he chooses to live and who s/he associates with. Notice that there is also a two-way arrow between ecological niche and sexual actions. This represents the idea that an offender's sexual offence may have an impact on his or her personal situation or environment regardless of the personal response. For example, a child sexual offender may claim that he is innocent, however, he may nonetheless lose access to his children.

The neuropsychological component plays an important role in the model as it represents the coming together of brain and behaviour. One particularly important example of this is the process of conditioning, which is associated with sexual offending. Because sexual gratification can be a very powerful reinforcer, the offence itself can strengthen deviant arousal and make further offending more likely.

With regard to problematic attitudes and beliefs, a similar process may take place. If an offender misinterprets the situation (either consciously or inadvertently) then the misinterpretation may bolster the maladaptive attitudes and beliefs. For example, if the offender believes that children enjoy engaging in sexual activity with adults, and then interprets a child's behaviour according to this belief, then the belief may be strengthened. Thus, for some criminals sexual offending may become more problematic the longer it continues because the underlying causal factors become more powerful as time goes by.

Another important factor that is indicated by this integrated model is the difficulties that may arise following conviction for a sexual offence. The ecological niche factors include variables such as personal and social environment which could conceivably play a very important role in on-going sexual offending behaviour. In terms of personal factors, one important issue is the fact that a sexual offender may have few social skills and few opportunities for establishing pro-social intimate relationships (e.g., Thakker, Collie, Gannon, & ward, 2008; Ward & Beech 2008). Furthermore, once an offender has committed even one sexual offence, it probably becomes even more difficult for the offender to establish such relationships. Sexual offenders are often harshly judged and even rejected by society (Thakker & Gannon, 2010) therefore it is difficult for them to establish and maintain friendships and romantic relationships. There may be a self-fulfilling prophecy here insofar as sexual offenders may believe that regardless of what actions they take, they will be forever branded a sexual offender and thus may as well behave like one. In this way, it may be theorised that the criminal careers of sexual offenders are, in part, associated with an interaction between their own personal characteristics and the social environments in which they reside.

Conclusion

This article has brought together two important bodies of literature; namely, theories of sexual offending and risk factors for recidivism with the aim of developing a theory of sexual recidivism. It is interesting to note the similarities across the various theories of sexual offending; this suggests that there is growing agreement about the factors that lead to this problematic behaviour. With regard to the analysis of factors that lead to sexual recidivism, there is also some agreement. However, there is clearly also a need for further research to clarify the relative salience of these variables. The model that has been presented is the product of an attempt to summarise the knowledge to

date. However, it is rudimentary and hypothetical and ripe for further elucidation, thus the goal herein is to provide a useful framework for further theoretical and empirical research in this area. For example, in terms of theory development, theoreticians may like to consider the links between various factors in the model and whether all factors play a role for all offenders. With regard to empirical investigations, the significance of various factors in the model could be tested in different offender groups. It is hoped that further research in the area will advance our understanding of sexual reoffending and ultimately lead to more effective interventions.

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Integrating Strength-Based Models in the Psychological Treatment of Sexual Offenders

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Abstract

In this paper we suggest that treatment for sexual offenders will be maximally effective if it is strength-based. We reject the negative and deficit focus of earlier approaches, particularly the *Relapse Prevention Model*. Effective treatment should incorporate the *Risk/Needs/Responsivity* principles outlined by Andrews and his colleagues, Ward's *Good Lives Model*, and Seligman's *Positive Psychology* approach. We have shown that such a strength-based treatment program effectively reduces long-term reoffending among sexual offenders.

Introduction

The onset of the modern era in the treatment of sexual offenders began with the reports of Isaac Marks and Malcolm Gelder, two psychiatrists working at the University of London's Institute of Psychiatry (Marks & Gelder, 1967; Marks, Gelder, & Bancroft, 1970). Their approach was based on the emerging behaviour therapy movement (Eysenck & Rachman, 1965) which was being enthusiastically implemented at the two hospitals (Maudsley and Bethlem Royal) affiliated with the Institute of Psychiatry. From this perspective sexual offending was viewed as an acquired behaviour that was driven by learned deviant sexual interests (McGuire, Carlisle, & Young, 1965). The aim of treatment was to reduce these deviant interests and increase appropriate interests.

Early studies suggested that this approach was effective (see Crawford, 1981; Kelly, 1982; for summaries of these studies), but it soon became apparent that the problems involved in sexual offending were a good deal more complex so more comprehensive programs were developed (Abel, Blanchard, & Becker, 1978; Marshall & Williams, 1975). Over time the array of issues addressed in treatment expanded (see Marshall & Laws, 2003; for a history) although not always based on sound evidence. In the late 1990s and in the early 21st Century, meta-analyses identified a set of potentially modifiable problems (called "criminogenic features") that were predictive of sexual reoffenses (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005). It was soon accepted that these criminogenic features (also referred to as "stable dynamic risk factors") had to be addressed in treatment (Hanson, 2006; Hanson & Harris, 2000).

Along with this expansion of the issues addressed in treatment, the most significant change was the introduction of the *Relapse Prevention* (RP) model by Marques (1982) which was adapted from Marlatt's (1982) approach with addictions. This model was instantly popular and was widely adopted across North America and subsequently in the United Kingdom and in various other countries. Despite its popularity the RP model has not been shown to be effective (e.g., Marques, Weideranders, Day, Nelson, & van Ommeren, 2005). The characteristic feature of RP is its emphasis on avoidance. This essentially negative approach is inconsistent with a body of research findings demonstrating that "avoidance goals" are rarely maintained whereas adopting "approach goals" typically leads to success (Emmons, 1996; Gollwitzer & Bargh, 1996). As a result, the RP model has been effectively criticized on these and various other grounds (Ward & Hudson, 1996; Ward, Hudson, & Siegert, 1995; Ward, Polaschek, & Beech, 2006; Yates, 2007; Yates & Ward, 2009), but the most important point is that it has been shown to be ineffective by its leading advocate (Marques, Weideranders, Day, Nelson, & van Ommeren, 2005). This finding, however, has not led to its complete abandonment. Indeed there are some (Carich, Dobkowski, & Delehanty, 2009) who continue to defend RP and claim that it has effective elements.

Our view is that the RP approach is ineffective because it is excessively negative and, as a result, de-motivating to sexual offender clients who are already typically lacking in motivation and hope. A number of programs, including our own (Marshall, Anderson, & Fernandez, 1999; Marshall, Marshall, Serran, &

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Fernandez, 2006; Marshall, Marshall, Serran, & O'Brien, 2011; Marshall, Ward et al., 2005) have dropped almost all RP elements while moving toward a more strength-based and empirically-derived program. We will now address the features of this recent approach.

A Positive Strength-Based Approach

There are essentially three models that are integrated into this approach and that serve to guide the design and implementation of treatment: the *Risk/Needs/Responsivity* model (Andrews & Bonta, 2006); the *Good Lives Model* (Ward, 2002); and the recent movement in clinical work described as *Positive Psychology* (Carr, 2011; Peterson, 2006; Seligman & Csikszentmihalyi, 2000).

The Risk/Needs/Responsivity model

The *Risk/Needs/Responsivity* (RNR) model was derived by Andrews and his colleagues from a series of meta-analyses of offender treatment outcome studies (Andrews, Zinger et al., 1990; Dowden & Andrews, 2004; Dowden, Antonowicz, & Andrews, 2003). They showed that programs that targeted high risk offenders, addressed criminogenic needs, and delivered treatment in an appropriate way, were very effective in reducing recidivism. Programs that adhered to two of the RNR principles were also effective but less so than those that addressed all three while those that adhered to just one had little impact and those that adhered to none of the three principles had either no effect or, in some cases, marginally increased recidivism. Subsequently, Hanson, Bourgon, Helmus and Hodgson (2009) demonstrated that the RNR principles applied equally well to sexual offender treatment. In Hanson et al.'s study, the *Risk* principle had quite small effects (as it did in Andrews' studies) so they suggested it was best viewed as an administrative guide for allocating resources rather than as a basis for designing and implementing a treatment program. It was the *Needs* and *Responsivity* principles that exerted the greatest influence on the effectiveness of treatment.

The *Needs* principle demands that treatment address those features of offenders that have been shown to predict reoffending; that is, the stable dynamic risk factors. Andrews and Bonta (2006) showed that the *Needs* principle when properly adhered to accounted for a substantial amount of the change produced by treatment (effect size = 0.19). The stable dynamic risk features (i.e., criminogenic factors) that have so far been empirically identified include: attitudes supportive of sexual offending (tolerance of offending, adversarial sexual beliefs, hostility toward women, emotional congruence with children); deficits in perspective-taking; poor coping skills; intimacy deficits and emotional loneliness; deviant sexual interests; sexual preoccupation; sexual entitlement; and behavioural, sexual, and emotional self-regulation problems. Programs that address all of these criminogenic factors are maximally effective; those that address less than all of them are less effective, proportional to the number they fail to address. In addition, some noncriminogenic factors may be usefully addressed in treatment but only if they serve to motivate the offenders (e.g., raising self-esteem) or if they are related to criminogenic factors (e.g., poor empathic skills are characteristic of people who lack intimacy). However the evidence indicates that addressing factors that are unrelated to criminogenic features reduces treatment effectiveness (Andrews & Bonta, 2006).

The *Responsivity* principle is concerned with the way treatment is delivered and it has two components: general and specific responsivity. The latter refers to the need to adjust treatment delivery to the unique features of each individual (e.g., his learning style and capacity, his social and culture characteristics, and his day-to-day fluctuations in mood and motivation). Many treatment centres have special programs for offenders with restricted cognitive capacities and we have adjusted the delivery of our program to accommodate the unique features of those clients who score in the psychopathic range on the PCL-R (Hare, 1991). However, the most important aspect of responsivity is the general principle.

The general component of responsivity has often been equated with employing a cognitive behavioural therapy (CBT) approach. For instance, Hanson et al. (2009) counted all CBT programs in their meta-analysis as adhering to the general responsivity principle when in fact, so-called CBT programs vary considerably in almost all aspects (see surveys by Burton & Smith-Darden, 2001; McGrath, Cumming, & Burchard, 2003; McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010). As Andrews and Bonta (2006) clearly demonstrated, the crucial features of the general responsivity principle are not necessarily met by adopting CBT but rather are captured by what they call the *Core Correctional Practices* (CCP).

Essentially the CCPs involve the appropriate delivery of treatment. They require therapists to be empathic, warm, supportive, respectful and motivational, and to reward the expression of prosocial attitudes and behaviors. These features are a match for what Miller and Rollnick (2002) call the "spirit" of motivational interviewing. Consistent with the CCPs, we (Marshall, Serran, Fernandez et al., 2003; Marshall, Serran, Moulden et al., 2002) have shown that expressions of empathy and warmth by therapists who are rewarding and somewhat directive are significantly related to beneficial changes among sexual offenders, whereas an aggressively confrontational style markedly reduces effectiveness. Similarly, Beech and his colleagues

(Beech & Fordham, 1997; Beech & Hamilton-Giachritsis, 2005) demonstrated that when therapists created groups that were cohesive and expressive, sexual offenders made significant treatment gains.

Thus, programs that adhere to the RNR principles, whether they are CBT or not, are very likely to be effective, whereas programs that fail to incorporate these principles (particularly the Needs and Responsivity principles) are almost certain to fail to generate benefits.

The Good Lives Model

The *Good Lives Model* (GLM) was derived by Ward (2002) from a large body of research on the human need for self-fulfillment. This body of knowledge indicates that all people, whether they are aware of it or not, seek to achieve success in several domains of functioning. Ward identifies nine such domains: (1) optimal mental, physical, and sexual health; (2) knowledge; (3) mastery in work and play; (4) autonomy; (5) inner peace; (6) relatedness; (7) creativity; (8) spirituality; and (9) happiness.

The GLM offers an approach to treatment that aims at providing offenders with the skills and attitudes essential to developing a more satisfying life. Ward (2002) suggests that, in their deviant acts, sexual offenders are seeking to fulfill the same needs that others pursue in prosocial ways. Accordingly, sexual offenders are seen as adopting inappropriate means to meet their needs. Providing them with sensible goals (i.e., the issues involved in the nine domains identified above) and the skills and plans necessary to meet these goals, will, therefore, constitute effective treatment. Interestingly, in their examination of treatment refusers, Mann and Webster (2002) found that one of the most common reasons sexual offenders gave for not entering treatment was that they believed it would not be aimed at helping them achieve what they wanted; they said they wanted treatment to provide them with the capacity to develop a better, more satisfying life. They believed treatment would simply focus on their offenses with the purpose being to stamp out their propensity to reoffend. Thus the offenders appear to want what Ward's GLM offers.

Ward, Collie and Bourke (2009) note that the criminogenic needs identified in Andrews and Bonta's (2006) RNR model simply reflect the absence of the skills necessary to achieve success in the domains the GLM identifies. Therefore, Ward claims, providing sexual offenders with an appropriate set of skills will necessarily overcome the deficits inherent in the criminogenic needs and will result in effective treatment. Adopting the GLM as a basis for treatment encourages a more optimistic and positive therapeutic approach that emphasises the development of strengths rather than focusing on deficits, as do treatment programs based on the *Relapse Prevention* model. In this sense the GLM is consistent with the recent Positive Psychology movement in clinical psychology which we referred to earlier.

Positive psychology

As Seligman (2002) points out, clinical psychology since the 1950s has been based on a deficit model where the focus in treatment has been on the client's failings and dysfunctions. This approach is embodied in the various editions of the American Psychiatric Association's *Diagnostic and Statistical Manual*, in which the criteria for Axis 1 and Axis 2 disorders are stated in deficit terms. Such an exclusive focus, so Seligman suggests, is demotivating and does not encourage the client to be hopeful. Positive psychology, on the other hand, equips clients with the skills necessary to fulfill their potential while at the same time not neglecting efforts to ameliorate the problems they have. It does so by assisting clients in identifying their strengths as a basis upon which to build and by doing so encourages effective engagement in treatment. As noted, this focus does not ignore the problematic aspects of the client's functioning, but these problems are construed as resulting from the absence of strengths which skills training can overcome.

As Ward and Stewart (2003) point out, building client's strengths, if directed appropriately, can reciprocally inhibit current difficulties. Indeed in some ways current treatment programs for sexual offenders have a strength-based focus. For example, building the skills, self-confidence, and attitudes essential to functioning effectively in relationships, necessarily allows the sexual offender to overcome deficiencies in intimacy and thereby reduce loneliness; both of which are criminogenic factors. In this sense the advantages of a positive psychology approach is the emphasis throughout treatment on building skills and it is in this focus that it is innovative. Instead of dwelling on deficits and stressing the need to avoid risks, a positive approach focuses on the client's potential for skill building and offers a hopeful view of the future. Instilling hope for the future in clients with various disorders has been shown to generate benefits from treatment and to reduce relapses (Snyder, 1994). Our preparatory program (L. E. Marshall, Marshall, Fernandez, Malcolm, & Moulden, 2008) significantly increased hope in sexual offenders, which in turn enhanced subsequent engagement in treatment and led to reductions in recidivism.

Another advantage of a positive psychology approach is that it explicitly states that clients should continue the development of their strengths after discharge from treatment. While relapse prevention programs also insist on continuing the processes addressed in treatment, the focus is still deficit-oriented. RP clients

are required to identify various circumstances, persons, and thoughts that they must continue to avoid because, it is assumed, they still have deviant propensities. Such a negative focus is not motivating and does not instil hope.

A Strength-Based Treatment Program

The main treatment program we provide in a prison setting (Marshall, Marshall, Serran, & O'Brien, 2011) incorporates the essential features of the RNR model, is framed around the GLM, is motivational, and emphasizes building the sexual offenders' strengths. For the most part, we ignore the details of their offense history and we do not require them to provide a disclosure of the details of their offense; much less one that matches the victim's report (see Marshall, Marshall, & Kingston, 2011; Marshall, Marshall, & Ware, 2009, for a discussion of this issue). This program has been evaluated by independent research assistants and found to effectively lower recidivism rates. At 5.4 years follow-up, the treated offenders had a sexual reoffense rate of 3.2% compared with an expected untreated rate of 16.8%, and at 8.4 years follow-up the respective rates were 5.6% versus 23.8%. While meta-analyses (Hanson et al., 2002; Lösel & Schmucker, 2005) have indicated overall positive outcomes for sexual offender treatment, the effects derived from our program are significantly larger than those apparent in any other program appearing in the literature.

Conclusions

We believe the emerging evidence from the general clinical literature encourages confidence that adopting a strength-based approach to treatment will result in significant treatment gains. When dealing with offenders of any type it is essential to adhere to the Needs and Responsivity aspects of Andrews and Bonta's (2006) *Principles of Effective Offender Treatment* while integrating this with Ward's (2002) GLM and focussing on the clients' strengths. The treatment outcome from our program for sexual offenders, which has all these elements, encourages optimism that this approach can be effective in other settings. We urge those who design and implement sexual offender treatment programs to adopt this positively focussed, strength-based approach and move away from the negative aspects of earlier programs.

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A Review of "Crime, Culture and Violence: Understanding how Masculinity and Identity Shapes Offending"

By Katie Seidler

Bowen Hills, QLD: Australian Academic Press, 2010

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At a time where much of the 'crime and culture' literature has focused on topical political issues such as terrorism, warfare, and human rights violations, this book focuses on more commonplace violence in Australian society and is a reminder that cultural understandings of aggression and violence are not only the business of the politically disenfranchised.

Drawing upon her prison interviews with 15 men sentenced for violent offences, Dr Seidler explores the complexities of crime and culture – specifically masculinity and violence. Her central argument is that cultural experiences influence the development of identity and relationships, such that people from different communities can have strikingly different experiences of the world, of themselves and of the people with whom they interact. From here, it is asserted that these same cultural processes are instrumental in shaping the motivations for – and choices in – criminal behaviour, particularly interpersonal violence. Moreover, this develops through the mediating influence of understandings of Self and of Other, whereby cultural experience affects people's beliefs, which in turn shape motivation for and understanding of criminal violence.

To assist the reader to traverse this rocky terrain, she provides an overview of general theories of crime, offering a basic framework for understanding offending behaviour as socioculturally-informed phenomena. This is followed by a working definition of 'culture' that is conceptualised as a dynamic process that permits complex engagement and interpretation rather than merely the observed idiosyncratic behaviour and beliefs of ethnic or geographically-related communities. We are then introduced to the men themselves who provide the source material that informs and illustrates the core themes of the book.

Using individualism and collectivism as a conceptual compass, the central chapters critically explore the impact of culture and identity in relation to the possible causes of violence, touching on cultural identity, crime and identity, group identity and crime, criminal identity, and masculine identity. Of interest, one chapter (with Dr Greg Noble) surveys common cognitive strategies that are used to support criminal behaviour and are recast in the light of the interviewees' cultural perspective to provide insights into how antisocial attitudes can be misconstrued as distorted cultural products.

The final section of the book offers constructive directions that have clinical, theoretical, criminal justice and community implications. For instance, clinicians are encouraged to be mindful of cultural experience and its impact, and to proactively attend to stories of culture in offender's accounts of their violence as an avenue for informing the individual's behaviour and to frame the context for therapeutic change. It is argued that understanding criminal behaviour in culturally-situated ways facilitates a deeper and richer understanding of crime and violence which is in accordance with the individual's lived experience – an approach that is in keeping with the principle of treatment responsiveness. Lastly, an appendix detailing the methodology that ultimately informed this book is included, and reflects the careful and sensitive approach adopted by the author.

Dr Seidler writes in an engaging and absorbing style that makes the material accessible without trivialising the complexity of the issues or compromising the integrity of her interviewees experience as perceived through their respective cultural lenses. Furthermore, the case examples are insightful and rich in detail without being gratuitous or sensational – a challenging feat given that much of the public interest in crime and violence is arguably predicated on a high level of moral outrage at the perceived severity of criminal acts.

The selection of case examples reveals men from immigrant communities as well as from dominant 'white' Australia, recognising multiple cultural heritage and that 'culture' is not solely the business of minority communities.

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It needs to be acknowledged at this point that 1) a book of this size (i.e., 202 pages) cannot possibly address the richness of this topic, and 2) no attempt is made at representativeness – the selection of the informants serves primarily to illustrate the complexity and range of issues. It is also noted that the voices of indigenous Australians are conspicuously absent. This is a pity and presents a gap of real interest given 1) the high proportion of Aboriginal men serving prison sentences, and 2) the unique sociocultural space that offenders from these indigenous communities occupy in Australia's broad social fabric.

Often, scope is achieved at the expense of depth, and vice versa. However, this book smoothly contextualises the subject, serving as both an excellent introduction to contemporary thought on the relationships between culture and crime, as well as a valuable contribution in understanding and managing violent behaviour through a careful consideration of culturally-informed and situated approaches. Furthermore, the straightforward and reader-friendly style would appeal to a wide audience that would include forensic, correctional, psychological, and legal professionals as well as those with a personal interest in violence.

This book makes an important contribution insofar as it recognises that culturally diverse offenders derive from pluralistic societies and that increasingly more sophisticated and sensitive approaches to collective and individual orientations are required to develop meaningful understandings of crime.

A Review of "Is This Normal? Understanding your Child's Sexual Behaviour"

By Holly Brennan and Judy Graham
QLD: Family Planning Queensland, 2012

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Family Planning Queensland has published a resource book for parents about understanding the sexual behaviours of children. The authors, Holly Brennan and Judy Graham have translated their substantial knowledge of children's psychosexual development into a highly informative and accessible booklet for parents. The publication, Is This Normal? Understanding your child's sexual behaviour (2012) is a colourful and clear reflection of contemporary theory and research in the field.

The 45 page booklet places children's sexual behaviour within the context of their psycho-social development. It has a reassuring style and appealing layout that is bound to put many anxious parents at ease with the knowledge that sexual behaviours are usually normal in childhood and should be talked about openly and positively. Contemporary issues in the sexual development of children, such as online and mobile telephone communications, are identified for their strengths and risks.

Traffic lights are used as a structure to recognise and understand the continuum of sexual behaviours amongst children and to inform parents of appropriate responses. Green light sexual behaviours are normal and healthy. Orange light sexual behaviours are concerning. Red light sexual behaviours are problematic or harmful. Case vignettes are used to demonstrate the different categories. Constructive and protective strategies for responding to children's sexual behaviour are provided.

While this booklet targets parents as the main audience, the accurate and concise information makes this publication a useful quick-reference for anyone who works with children. It serves well as an introductory booklet for teachers and other non-clinical professionals as it contains a substantial reference list that encourages a closer examination of the topics raised. The traffic lights chart is particularly helpful in identifying green (low risk), orange (moderate risk) and red light (high risk) behaviours according to children's age-groups: being 0-4 years, 5-9 years, 10-13 years, and 14-17 years.

The booklet has further application to that of providing information to adults. The traffic lights framework is a tool that parents and workers can use with children when teaching them about healthy, concerning and harmful behaviour. This book would make a very solid contribution to primary and secondary abuse prevention efforts if it were made widely available to the whole community, and particularly to the carers of children.

Is This Normal? Understanding your child's sexual behaviour is available directly from Family Planning Queensland at the cost of $14.90 per copy. Order online at www.fpq.com.au.

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